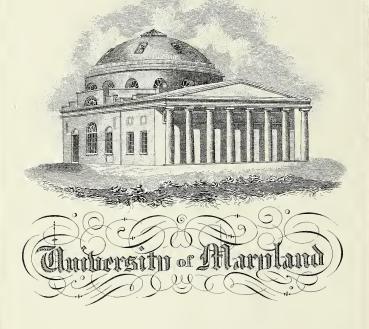


School of Medicine











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JANUARY, 1944

VOL. XLV, No. 1



New, effective treatment for the most baffling Peptic Ulcer

Gastrojejunal ulcer is described as the type most difficult to treat satisfactorily. 1.

A new preparation, Phosphaljel, is effective in treating these highly resistant lesions. 2.

Phosphaljel is antacid, astringent, demulcent, pleasantly flavored. It is indicated in those cases associated with pancreatic juice deficiency, diarrhea, or low phosphorus diet.

Available in 12-fluidounce bottles, A pharmaceutical of John Wyeth & Brother, Division WYETH Incorporated, Philadelphia.

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PHOSPHALJEL* Myethis

ALUMINUM PHOSPHATE GEL

THE JOURNAL of the

KANSAS MEDICAL SOCIETY

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Volume XLV

JANUARY, 1944

Number 1

VISCERO UROLOGIC COMPLICATIONS*

O. W. Davidson, M.D.

Kansas City, Kansas

Upper urinary tract pathology frequently presents confusing visceral symptoms. In fact so frequently that approximately fifty per cent of the cases with upper urinary tract pathology already have abdominal scars when they come to the urologist for treatment.

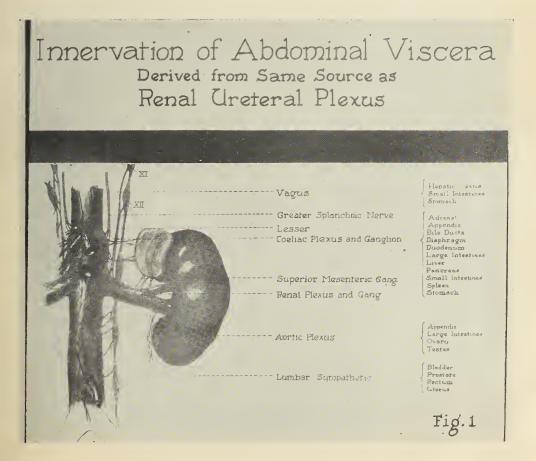
While such cases make up a rather large percentage of the urologists' practice, it must be borne in

*First of a series prepared for the Journal of the Kansas Medical Society.

mind that he sees a relatively small percentage of all the cases who have abdominal symptoms.

The purpose of presenting this series is to emphasize the importance of urologic study in the differential diagnosis of many abdominal symptoms. The fact that the urologist frequently finds himself working in virgin territory so closely associated with an over worked field should encourage him to review the virtues of urologic study.

The history of abdominal pain may mean almost anything. A whiff and sink test of the urine hardly justifies elimination of the urinaty tract from further suspicion. In fact the voided urine in true urologic condition may be entirely normal by any test and urinary symptoms may be entirely lacking. Why? Because the dominate urinary symptoms are referred



to remote areas, and the urine specimen from such a case may be entirely misleading.

Gastrointestinal manifestations, with abdominal pain, distention, nausea, and vomiting, may be the only symptoms. Confronted with such symptoms and normal urine, attention is not often directed to the urinary tract until the patient has run the gamut of other diagnostic and therapeutic procedures.

Abdominal scars, innocent surgical specimens and prescription records, too frequently represent sacrifices to the deceptive symptoms of urologic lesions. Every system in the body seems to enjoy abdominal publicity, especially for their anonymous contributions.

The interpretation of complex abdominal symptoms is enhanced by a thorough knowledge of the intercommunicating nerves and the peculiarities of all diseases common to the abdomen and pelvis.

Figure I shows the renal intercommunication of the vagus which also supplies the hepatic plexus, small intestines and stomach. Branches of the greater and lesser splanchnic nerve the coeliac plexus, superior mesenteric granglion and the renal plexus also supply the adrenals, appendix, bile duct, diaphragm, duoedenum, large intestine, liver, pancreas, small intestines, spleen, and stomach. The aortic plexus supplies branches to the appendix, the large intestines, the ovaries and the testes. The bladder, prostate, rectum and uterus are supplied by the lumbar sympathetics.

Renal or ureteral calculi, pyelonephritis, hydronephrosis, ptosis, renal tuberculosis, polycystic kidney disease, duplication of the renal pelvis, tumor and other lesions of the urinary tract are frequently the unsuspected sabateurs of abdominal comfort.



F.42. "PAIN RIGHT WHERE IT WAS 2 YRS. AGO WHEN MY G.B. WAS REMOVED." G.B. REMOVED BECAUSE OF VOMITING AND PAIN IN R.U.Q. THAT RADIATED TO RT. SHOULDER BLADE. UROLOGIC STUDY... RT. HYDRONEPHROSIS.

Fig. 2

For example consider the case of a female, fortytwo years of age, shown in figure II who had been treated over a period of several years for digestive disturbances. She had taken various and sundry remedies advised by druggists and friends. Her pain had been severe enough at times to require morphine. Nausea, vomiting, headaches, weight loss and generalized abdominal pain were the complaints for which she sought relief. Prior to urologic study she had been subjected to surgery. Her first statement on this last admission was, "Pain right here in my right side



where it was two years ago when my gall bladder was taken out." Pathological records revealed that surgical specimen were essentially negative.

Due to a suspected tubercular hydronephrosis the right kidney was removed. Happily for the patient no tuberculosis was found. The patient gained weight readily and has enjoyed exceptionally good health since February of 1931.

A review of urologic cases show numerous instances in which various remedies, diagnostic procedures and even surgery has been resorted to, before urologic study. Most of these diagnostic errors and erroneous procedures are the result of incomplete investigation, or the faulty interpretation of subjective symptoms, physical findings and laboratory data.

The emergency is seldom so great as to contraindicate proper consideration and study of the urologic tract. Persistent abdominal symptoms certainly invite urologic study.

Pointing out that certain types of malaria, such as falciparum, may be difficult to recognize due to the wide variety of symptoms, Harry Most, M. D., and Henry E. Meleney, M. D., New York, warn in The Journal of the American Medical Association for January 8 that "Every passenger and crew member of an airplane returning from a malarious region should be instructed to obtain medical attention on the first development of any symptoms of illness, even those of a common cold. ... Every patient returning from the tropics should have a thick and thin blood smear examined for malarial parasites, and if negative this should be repeated every twelve to twenty-four hours until malaria is confirmed or excluded...."

MANAGEMENT OF THE BLEEDING NIPPLE*

H. H. Hesser, M.D.

Kansas City, Kansas

Much has been written concerning the management of the patient with a definitely malignant tumor of the breast who presents herself to the physician. Certain ideas concerning the classification and the treatment of these cases have become crystallized into definite criteria for management.

Benign tumors of the breast, on the other hand, have presented a conflicting array of medical, surgical, radiological and pathological opinions lacking in uniformity in many respects. There are more than twenty-five different names for so-called chronic cystic mastitis, none of which satisfy the pathological or clinical picture of this condition. Whether or not certain of the benign breast tumors are precancerous lesions has drawn from capable investigators conflicting opinions. The management of the bleeding nipple is another of the many unsettled questions and is in need of clarification.

Bleeding from the nipple, which signifies that the causative lesion has originated within or has secondarily invaded the ductal system of the breast, is not infrequently one of the symptoms that causes anxiety on the part of the patient. This symptom is recognized by surgeons and pathologists as indicative of pathology of the mammary gland but unfortunately its significance as well as its bearing on treatment causes conflicting opinions. In 1899 Minz¹ was so impressed with the frequency of malignancy in cases of bleeding from the nipple that he advised simple mastectomy for all such cases. In 1907 Von Saar² stated that there is no relationship between bleeding from the nipple and carcinoma. Bloodgood3, in 1908, found that less than one per cent of his cases of carcinoma of the breast had bleeding from the nipple. His studies revealed that a patient with a lump in the breast and bleeding from the nipple which has not been noticed longer than a month has an eighty per cent chance of having a benign lesion. In 1915 Rodman4 regarded tumors situated immediately behind the nipple with a sanguinous discharge from the nipple in patients between fortyfive and fifty years of age as being potentially malignant from their inception. In the following year Dean Lewis⁵ stated that he believed that a serohemorrhagic or brownish discharge from the nipple is not a clue to malignancy, but is associated with in-

tracanalicular papilloma or the adenocystic type of chronic cystic mastitis. Deaver and McFarland⁶ in 1917, interpreted blood from the nipple as being attributable in the majority of cases to benign intracanalicular papilloma. In the same year Greenough and Simmons⁷ reported twenty cases of papillary cystadenoma of the breast. In eleven there was a sanguinous discharge from the nipple and three of these were found to be malignant. In 1925 Topie⁸ stated that, in a few cases, loss of blood from the nipple results from benign intracanalicular papilloma, but most frequently the bleeding results from endocanalicular carcinoma. Adair9 stated in 1931 that a dark bloody discharge from the nipple is always indicative of a ductal carcinoma. In the same year Bloodgood3b concluded from a review of his cases with discharge from the nipple that had not been operated on that these patients run no more risk from developing carcinoma than does a woman with no discharge. Cheatle and Cutler¹⁰ in the same year, regarded the discharge of serum or blood from the nipple as a stage of development of cystophorous epithelial hyperplasia which is considered as precancerous by them, or from carcinoma in the majority of cases. In 1933 Wainwright¹¹ stated, "In benign cases any type of lesion, local or diffuse, may cause bleeding or discharge from the nipple. Duct papilloma is the most common cause. There may be a diffuse epithelial hyperplasia or there may be no definite cause evident even though numerous whole breast sections are examined." In 1935 Stowers¹² in an excellent review of the literature, came to the conclusion that a discharge of serum or blood from the nipple with or without a palpable tumor is a surgical condition.

Thus, from the later part of the previous century to the present time the difference in opinion regarding bleeding from the nipple has existed.

In spite of this lack of agreement among men who have pioneered in the field of breast pathology, we, as physicians, should have certain definite ideas concerning the management of the case of bleeding from the nipple.

A rational approach to this problem is suggested in the following: If bleeding from the nipple is not accompanied by a palpable tumor at the time of the initial examination of the breast, estrogenic therapy over a period of six months should be followed. 10,000 units of estrogenic substance should be administered intramuscularly at weekly intervals for a period of two months, every two weeks for a period of two months, and once monthly for two months. If, at the end of this six month period, bleeding from the nipple is still present simple mastectomy should be performed. The adverse psychological influence

^{*} Presentd before a recent meeting of the Wyandotte County Medical Society in Kansas City.

of a bleeding nipple in many instances will cause the patient to request definite and complete relief at the end of this treatment period. If, in addition to the bleeding nipple, a related, palpable tumor be present at the time of the initial examination, local excision of the tumor with immediate frozen section study is indicated. If a study of the section reveals no suspicious invasion of the stroma by epithelial elements then sufficient surgical therapy has been rendered. On the other hand, if the frozen section shows signs of malignant invasion and no palpable axillary adenopathy be present, mastectomy which includes the external fascial layers of the pectoral muscles and axillary exploration should be performed. Radical mastectomy is indicated if axillary adenopathy is a part of the malignant picture.

SUMMARY

- 1. Bleeding from the nipple is one of the many questions concerning breast pathology which is in need of clarification.
- 2. A review of the literature reveals a definite disagreement as to the relationship of bleeding from the nipple to malignancy.
- 3. A rational therapeutic approach to the problem is suggested in the following:
- a. Estrogenic therapy with observation for a period of six months is recommended for bleeding from the nipple without a palpable associated breast tumor. Simple mastectomy is recommended if bleeding be still present at the end of the six month period.
- b. Local tumor excision is recommended for benign tumor associated with bleeding from the nipple.
- c. Mastectomy including removal of the external fascial layers of the pectoral muscles with axillary exploration is recommended for suspiciously malignant tumors associated with bleeding from the nipple without palpable axillary adenopathy.
- d. Radical mastectomy is recommended where axillary adenopathy is a part of the malignant picture.

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MODERN MEXICAN **MEDICINE***

C. Howard Darrow, M.D.

Denver, Colorado

As I have had occasion to spend several enjoyable months in Mexico during the past several years I feel it my duty to convey some of my observations and impressions from a medical viewpoint to my confreres.

Public opinion in the United States toward Mexico, not only as to medicine but concerning the value of her culture and the solidity of her political institutions, is one of ignorant good will combined with skepticism. It is thought there can be little in so turbulent a country to command serious attention. However, nothing could be farther from actuality. Her medical history along with her social organization run deep into the beginnings of her culture which was centuries old when the white man made his advent upon this continent.

My first visit to the interior of Mexico was during the winter of 1935-36 at which time I spent three months in Mexico City and its vicinity. The Federal District of which Mexico City is the chief part is situated in a high valley, 7,415 feet above sea level and before this valley was drained in 1900, heavy rains caused rivers and lakes to overflow the city, bringing epidemics of typhoid and other diseases. The city stands seventh in America and seventeenth in the world as to population. Its inhabitants now number 1,749,916 according to the 1940 census, an increase of 37.8 per cent over that of 1930 and twice the figure shown in 1920. This increase has occurred in spite of a considerable exodus of foreigners and is accounted for chiefly by immigration from the rural zones of the southern states. While the towns and villages of the Federal District have only a population of 233 people to the square kilometer (five-eighths of a mile), Mexico City has a mean population of 10,951 inhabitants per square kilometer and some parts of the city have 27,927. The highest infant and child mortality occurs naturally in these poor and overcrowded districts and in the suburbs where sanitation is faulty. During the ten-

Reprinted from the Rocky Mountain Medical Journal, November

year period before the 1940 census there were born 1,478,405 children in the Federal District, but only 971,800 were alive at the time of the census which means one child out of three dies before reaching its tenth birthday. It was interesting to learn that only four per cent of the residents owned their own homes. Many of the natives wear "huaraches" (sandals) or go barefoot, but as one visits Mexico from time to time he sees a constant change for the better. They are becoming modernized as to marriage and divorce and statistics disclose that while marriages are increasing moderately divorces are three times what they were ten years ago. Eye diseases are very numerous. Disfigurement from smallpox, leprosy and pinta mal is not infrequently seen, particularly in rural districts.

The Federal Government is anxious to forward the development of the practice of medicine in Mexico and consequently offers to educate medically any worthy student who may apply for such instruction. Consequently there is no tuition for such education in the medical department of the National University of Mexico, situated in Mexico City. This University, which is by far the leading one of the country, has an enrollment in all of its departments of about 16,000 students. Other cities, especially Monterey and Guadalajara, have good facilities for medical instruction. Although only one year of college work is required before matriculation at the University of Mexico, the student has gained much more in scientific studies before graduation from high school than is obtained in the United States; consequently the standard for entrance into the study of medicine is not greatly inferior to that of this country. The medical student is allowed to practice medicine beginning with the first year of his training. However, he must indicate on his sign and otherwise that he is not a graduated M. D. Although there is no internship required as a rule, his last year in medical college is occupied by visits to clinics and hospitals where the clinical and practical side of medicine is stressed.

There is a recent law governing future graduates in medicine that requires that they serve six months in the service of their government at a very small pay amounting to one peso (seventeen cents) a day. This service requires about three to five hours a day, but the physician is allowed to conduct a private practice outside of the above-mentioned hours. Physicians do not specialize to any extent in the smaller cities and rural districts.

Medical organization in Mexico, in my opinion, is rather deplorable at the present time. There seems to be a decided wrangling among the members of the profession throughout the country, especially in

the smaller communities. This situation is made worse since there are no laws to prevent anyone from treating the sick, with the exception of those who do not hold an M.D. degree cannot sign death certificates, perform autopsies, or write narcotic prescriptions. But through some friend or associate, consequently the country is over-run with irregular practitioners. However, in the capital I was favorably impressed with the comparatively high quality of medical practice especially as observed in the various hospitals, which I shall endeavor to describe briefly.

The Jesus Hospital was established in 1524 by Cortez, the conqueror of Mexico, and has been in constant use since that date. The structure is built of beautifully hewn stones, the interior being furnished with fourteen varieties of fragrant Mexican cedar. It is a charitable institution, perpetually endowed by Cortez who charged his descendants in Spain with the duty of caring for the institution. It has been modernized so that it is chiefly its outer appearance and surroundings that indicate its true age. There is an added interest when one realizes that it was established one hundred years before Plymouth Rock felt the step of the first New England colonist. Its inception was 227 years before the Pennsylvania Hospital was erected in 1751—the first in the United States.

Hospital Juarez, founded in 1569, accommodates part of the medical department of the University of Mexico. The remainder of this department is in an ancient building that also houses the Academy of Surgery. The hospital marks the sight of the old Spanish Inquisition and is near the Zocalo, familiar to those who have visited Mexico City. It is an institution of 1600 beds, with attractive surroundings and patio. It handles chiefly accident cases and other acute surgical conditions. I witnessed many creditable operative procedures including those of neurosurgery. Here I saw the first patient that I could feel had been cured of caricinoma of the esophagus. The operation had been performed six years before, leaving the upper end of the esophagus draining through the skin of the back. It was also at the Juarez Hospital that I witnessed my first transusion by use of blood from the dead. Later I watched Dr. Edward Urebe Guerala "operate" on an accident victim that had died during the previous night. The internal jugular vein was opened and under aseptic precautions he removed about one and one-half quarts of blood. The procedure must be carried out within ten hours after death to prevent decomposition. The body is placed head down for at least ten minutes before-hand. The blood is cultured and a Wassermann test performed; it can be kept for thirty days at two degrees Centigrade.

The Spanish Hospital, built for the Spanish colony of Mexico City, consists of many one-story buildings with over a thousand beds. It is an immaculate institution, attractively constructed with free use of colored tiles. All bassinets in the nursery are covered with large, blue, mosquito-netting canopies, tied with pink bows. And in the modern operating suite pink linen is employed.

The British and American hospitals are smaller, less modern and less colorful.

The General Hospital consists of forty buildings, each surrounded by gardens and trees. Each building has approximately forty beds and is devoted to separate specialities such as obstetrics, orthopedics, cardiology, and infectious diseases. I was very much interested in seeing many patients with rhinoscleroma, a nose and throat condition of which I had frequently read but had never seen. The disease usually begins in the pharynx with loss of the uvula followed by sclerosis and scarring of the soft palate and surrounding tissues. Similar pathology is frequently found in the larynx, with stenosis to the point of suffocation unless dilatation with heated bougies is utilized. Likewise the disease affects the nose with complete obstruction of the nasal passages if similar treatment is not constantly repeated and that a times proves of no avail. Rhinoscleroma is very prevalent especially in southern Mexico from where patients travel to Mexico City for treatment. During my absence from home a patient with the disease, the first to my knowledge to be recognized in Colorado, was shown before our state otolaryngological society.

The National Railroad Hospital which was completed during my first visit to Mexico, is one of the most up-to-date I have ever visited anywhere. It was built by the government at enormous expense. Free medical care is provided for all railroad workers and their families. The building is entirely air-conditioned including the operating rooms which are equipped with an electric eye that controls the entrance doors. All anesthetic gases are piped to the operating rooms. Ceilings above the operating tables are of clear glass with observation units directly above. A loud speaker extends from the operating rooms so that the observers can be kept informed as to proceedings below.

The anesthetic agent in common use in all the hospitals was balsoforme. This is a French mixture of ether seventy per cent, chloroform, ethyl chloride and gomenol oil. The material is poured into a metal ball six to eight inches in diameter, fitted onto a face mask which in turn is connected with a rebreathing bag. The advantages claimed were quick induction, economy and freedom from "postoperative"

pneumonia." Surgical instruments were chiefly of French or German design, the former predominating. Other French influences could be observed, such as surgical technic and the fact that medical students study from French and not Spanish textbooks. I was informed that this reverts to the French regime in Mexico; that most postgraduate work in the past has been in Paris and the fact, as just mentioned, that medical students study from French textbooks.

I was fortunate in becoming acquainted with some American physicians practicing in Mexico, members of my own specialty and a number of medical students, all of whom were very gracious and helpful to me while I was attempting to gain some knowledge of medicine as practised in that country.

It has been said that Mexico is a country of extremes. Parts of Mexico City and other cities of the Republic have as modern architectural design, its residents as well educated and cultured as any in existence. Yet many of the inhabitants of the country are actually centuries behind modern civilization, living just as primitively as their Indian ancestors. The same contrast is found in medical practice and hospital care. As an example of the latter there is a hospital in Cuernavaca, a city of about 15,000 people, fifty miles south of Mexico City, capable of housing about one hundred patients many of whom are acute surgical cases. When I visited the institution the total expense per patient, per day, was only forty centavos (then about ten cents in our money). The equipment was deplorable with no pressure sterilizers and only bone-handled surgical instruments. An interesting observation was the occasional unoccupied bed prepared for the next patient with the old-fashioned chamber pot resting on the middle of the pillow at the head of the bed.

RURAL DISTRICTS

In the early spring of 1940 I traveled approximately two thousand six hundred miles in the western and southern parts of Mexico, stopping first at Guaymas (pronounced Y-mas), an excellent fishing resort on the Gulf of California. From Guaymas we journeyed six hundred miles southeastward of Mazatlan, also on the western coast of the country, passing through some of the most primitive, rural districts including the "jumping bean" section. Some of you may remember reading an interesting article not so long ago in one of our weekly magazines. It is in such parts of southern Mexico that you see medical practice at its worst, with the witch doctor, still predominant. Here natives can be seen wearing their charms, such as snakeskins and head bands to cure their maladies or ward off disease. John Steinbeck, the writer, says, "they are people who live in a long moment when the past slips reluctantly

into the future. In the little pueblos where the coming of babies and corn are important things of life, superstition and death lurk. The water which brings life to the corn brings death to the babies. The charms of the wise women, all the snakeskins and herbs cannot drive the deadly little animals from the polluted wells."

Traversing four hundred miles of countryside north and east from Mazatlan one passes through the tequilla-growing district where tequilla can be purchased for one peso per gallon. At the end of this trek you arrive at Guadalajara, second largest city in Mexico. Here one finds another good medical school at the University of Guadalajara, founded in 1796. Although there is no pre-medical work required, the curriculum covers a six-year period followed by a year as "practicante" (somewhat less than an internship). The faculty and students form an enthusiastic group, and I was surprised to learn how well informed they are regarding modern medicine in the United States and other countries.

The Charity Hospital is an old building of very unusual construction. One can stand under a dome in the center of the structure and see 500 bed patients. This is made possible by the fact that two rows of beds decorate each of six corridors radiating from the central unit which formerly was a shrine but now is a nursing station.

In 1939 a private sanitarium was opened for the care of tuberculous patients but in 1940 there were still no hospital facilities for the treatment of charity cases.

Guadalajara also has an orphanage where some 700 children are cared for by the government. In conjunction there is a home and infirmary for the aged. The city, as a whole, is an interesting place with many beautiful homes. The crimson and violet bougainvillia, blue jacaranda trees, red poinsettias and other flowers that grow in profusion make a riot of color.

RECENT IMPROVEMENTS IN GENERAL HEALTH

TUBERCULOSIS—Mexico has a population of about 16,500,000 people, of which 1,500,000 are white, 5,000,000 are Indian and 10,000,000 are of mixed Spanish-Indian extraction (Mestizo). It is the last class that furnishes the great majority of tuberculosis patients, far in excess of its proportion of the population. They are the people that live in the industrial centers; ports such as Tampico, Vera Cruz and Mazatlan, as well as the mining districts where silicosis is common. Even in the rural districts, especially those in the tropical zones, where malaria, hookworm diseas, etc., undermine the general health, tuberculosis is widespread. Along the northern border, particularly at Matamoras, Nuevo

Laredo and Nogales, Sonora, the number of tuberculous patients is high due to deporatation from this country.

It appears that the people ignore the disease and seek medical advice only when forced to do so by poverty or when unable to work. It is estimated that only ten per cent are in the incipient stage, twenty per cent moderately advanced, and seventy per cent far advanced. It was interesting to observe that the mortality rate from tuberculosis in Mexico City in 1900 was 500 per 100,000 population but from that year until 1930 it fell to 130. This reduction was apparently not due to the results of well known measures but to those that made for general improvement in living conditions among laborers, as a consequence of the movement in Mexico by the Federal Government toward social improvement of the masses. In-1938, taking the country as a whole and including all forms of disease, the mortality rate was 55.38, not so different from our own country.

The first public sanitarium for the treatment of tuberculosis was opened in 1936 or early in 1937. Cases prior to that time were cared for only in general hospitals. The fight against tuberculosis began about ten years ago when several measures were taken by the National Tuberculosis Commission, Division of Tuberculosis of the Federal Department of Health and the Department of Public Assistance.

The present number of beds in official institutions amount to about 1,000 plus about 100 in private sanitaria. However, the number of tuberculosis clinics has increased materially in the past six years. There are now eight in the Federal District and twenty-five scattered over the nation and in the most stricken areas. The National Tuberculosis Commission in 1941, through a drive for funds, raised 750,000 pesos by the sale of stamps to form sort of a social security against the disease. The apparently greater susceptibility of Mexicans in this country is not due to their nationality but to their poverty, bad housing and poor hygiene coupled with dangerous occupations and contracts allowing child labor.

MALARIA—Although the mortality rate of malaria was reduced from 173.21 per 100,000 population in 1922 to 127.11 in 1938, it is still one of the greatest public health problems in Mexico, particularly in the tropical, rural zones and along the coasts. Very few special studies have been carried on until just recently regarding its prevalence, the mass immunity and bionomics of the species of anopheles present, but the Bureau of Biostatistics believes that there are more than 5,000,000 patients every year. Malaria stands third among the most common causes of death, diarrheas and enteritis exacting the greatest toll while the pneumonias rank second. A cinchona

plantation in the state of Chiapas where 24,000 cinchona trees have been planted supports a laboratory for the manufacture of quinine products. From this laboratory a ton of quinine has recently been shipped to malaria areas of the Republic with other and larger shipments to follow. There is a free distribution of all anti-malarial medicines by the Federal Government whose 1942 malarial budget called for, in addition to the amount collected from the mosquito stamp, 1,000,000 pesos (\$175,000.00).

TRANSFUSION SERVICE—Even before Mexico or the United States entered the war there were three large and sevral small blood transfusion enters in Mexico City. The largest is at the Juarez Hospital where a majority of accident and emergency patients receive care. There is also one at the General Hospital, and still another is maintained by a private group of physicians. In addition there is a small transfusion unit in each of the other hospitals. I understand they are using more fresh-drawn blood and plasma than formerly. Usually relatives of the patients are typed and cross-matched with Wassermann determination before elective surgery is performed. For emergency situations a telephone message is sent to any blood center and fresh blood is drawn from donors who have been previously examined, classified, and placed on the donor list. The blood is drawn under pressure, using oxygen and no citrate, into a sterilized ampule, and then delivered to the recipient within thirty minutes to one hour after the request is received. It is dispensed from the container in which the blood is collected. The physician at the center who draws the blood frequently administers it to the recipient, and charges ten pesos for his services. Twenty to twenty-five pesos for 100 c.c. is the usual charge for blood. Patients pay the donor and the dispensing physician for the blood if they are financially able to do so. If not, the government pays for it. In extreme emergencies the nurses of the hospital donate their own blood.

GENERAL CONSIDERATIONS

The Federal Government of Mexico through its minister of public assistance, Dr. Gustavo Baz, is promoting the improvement of hospitals throughout the country. Civil hospitals are to be erected in all of the larger cities such as Monterey, Pueblo, Vera Cruz and Tampico. Most of this work is expected to be started this year (1942), but may be delayed on account of war conditions. In addition to the above-mentioned hospitals a large medical center is to be built in Mexico City with all modern facilities for patients coming to the capital for treatment.

Since the outbreak of war in this country the Institute of Hygiene of the Federal Department of Health, through its chemists and bacteriologists, have

been materially increasing the manufacture of biologic products which were chiefly imported at a high cost.

South of the Rio Grande we have a friendly neighbor with whom we have an ever-increasing traffic and with whom we are now allied in war. We share mutual medical problems as well as many other interests that can be of inestimable value to all concerned if only cultivated by a spirit of tolerance.

I shall feel well repaid for my efforts to paint briefly a word picture of medical Mexico if I have aroused sufficient interest in my readers to cause them to pursue their own investigations by a visit to this enchanting country of extremes.

Browsing through Mark Twain the other evening we were struck by the analogy between the training of a river pilot and that of the surgeon. Remember, in Life on the Mississippi, Clemens' discussing the pilot?

It goes like this: "A pilot must have memory; but there are two higher qualities which he must also have. He must have good and quick judment and decision, and a cool, calm courage that no peril can shake. Give a man the merest trifle of pluck to start with, and by the time he has become a pilot he cannot be unmanned by any danger a steamboat can get into; but one cannot quite say the same for judgment. Judgment is a matter of brains, and a man must start with a good stock of that article or he will never succeed as a pilot.

"The growth of courage in the pilot-house is steady all the time, but it does not reach a high and satisfactory condition until some time after the young pilot has been 'standing his own watch' alone and under the staggering weight of all the responsibilities connected with the position. When the apprentice has become pretty thoroughly acquainted with the river, he goes clattering along so fearlessly with his steamboat, night or day, that he presently begins to imagine that it is his courage that animates him; but the first time the pilot steps out and leaves him to his own devices he finds out it was the other man's. He discovers that the article has been left out of his own cargo altogether. The whole river is bristling with exigencies in a moment; he is not prepared for them; he does not know how to meet them; all his knowledge forsakes him; and within fifteen minutes he is as white as a sheet and scared almost to death. Therefore pilots wisely train these cubs by various strategic tricks to look danger in the face a little more calmly.'

Substitute surgeon for pilot; operating-room for pilothouse; operation for river; instruments for steamboat; and you have what we mean. The likeness can be applied to any highly trained specialist who must accept grave responsibilities. It applies to industry as well as to the professions.

The anxiousness of the novice to jump into deep water might well be somewhat curbed by a full reading of Life on the Mississippi. The "old salt," too, would be amused by a rereading of Mark Twain's homely philosophy and native humor.—The Bulletin, Onondaga County.

President's Page

To the Members of the Kansas Medical Society:

Many physicians, the American Medical Association and some of your officers feel that as a medical society, we should attempt to do something in a concrete way, to help us in the eyes of the public and to prevent the Federal Government from taking us over, lock, stock and barrel.

Some months ago, I asked the Committee on Medical Economics of our state Society to undertake a study of this problem. At the council meeting in Topeka on January 9, Dr. Barrett Nelson of Manhattan made a report showing a lot of work done and keen insight of the problem.

In the discussion of this problem, the committee stated very definitely that any prepayment plan should be entirely operated by the medical profession. One plan would indemnify the client, up to a certain specified amount for surgical, orthopedic and obstetrical care. As a general rule plans that have attempted a complete over-all medical coverage have had trouble, and there is just not enough statistical data available on a complete program. There are many plans, successfully operating, providing surgical, orthopedic and obstetrical care and so far as I know, none have gotten into trouble. Dr. Nelson and his committee will continue their studies and make definite recommendations at our meeting in May.

I confess that the plan has much appeal to me, since it will give us good grounds to fight socialization of medicine. Some physicians have said to me, "Why do anything?" Regardless of what we might desire, I am convinced that unless we meet this issue some governmental agency will meet it for us.

I again call your attention to the work of the post-graduate committee, headed by Dr. Harold Jones of Winfield. They have a big, tough, and interesting job. There is no active physician in the state today, who is not willing to help provide post graduate study for our men returning from military service. Just stop and think what that man has given up, the sacrifice he has made to fight a battle that you and I could not take part in. I trust that every member in our Society will take these two projects very much into their own hearts and minds.

Sincerely,

J. L. Lattimore h

President, The Kansas Medical Society

EDITORIAL

ANNUAL SESSION

The plans for the 85th annual meeting of the Kansas Medical Society which will be held in Topeka on Wednesday, May 10, and Thursday, May 11, 1944 are going forward.

The Topeka Municipal Auditorium has been reserved and the usual meeting plans for scientific and commercial exhibits are under way in the central office.

The House of Delegates meetings are scheduled for Wednesday, May 10, at 9:00 a. m. and Thursday May 11, at 4:00 p. m.

The Shawnee County Medical Society will be this year's hosts to the meeting and although the number of days for the meeting has been reduced from the usual three or four to two it is believed shortening the meeting time will bring a larger number of the profession to Topeka on those two days. Shawnee County members chosen to head committees for the meeting are as follows: Chairman of the Program Committee, Dr. Dwight Lawson; Chairman of the Social Committee, Dr. E. H. Decker; Chairman of the Committee on Scientific Exhibits, Dr. W. J. Walker; Chairman of the Committee on Local Arrangements, Dr. V. C. Wiksten, and Chairman of the Committee on Commercial Exhibits, Dr. Leo A. Smith.

Dr. Wiksten, Chairman of the Committee on Local Arrangements, has announced his committee members who include: Dr. J. G. Stewart, Dr. M. B. Miller and Dr. W. W. Reed. Other committee announcements will be made in the next issue of the Journal.

We hope you will mark your calendar now and make plans to attend the two days session in Topeka on May 10 and 11, which is being streamlined along war-time lines.

WOMEN'S FIELD ARMY IN KANSAS

In spite of the additional duties imposed by a nation at war the officers and members of the Kansas Women's Field Army have gone steadily forward this past year, disseminating information, and educating the public under their slogan "Fight Cancer With Knowledge." This year a war-service program was put in operation for the group to unify efforts, increase efficiency and economize on time and energy spent.

Sixteen educational conferences were held during the year, and in the state this type of conference is usually of one day duration with physician speakers, films, and training program for the field workers. As an education to the public program in Kansas many talks have been held and films shown before various groups and clubs, as well as quantities of literature distributed. Mrs. J. E. Johntz, as state commander of the Kansas Women's Field Army, and the members of her organization are to be congratulated on the fine work they have done in the past year.

Statistics from the Kansas State Board of Health inform us that from January to October 1943 inclusive there were 1,942 cancer deaths in Kansas. It is too early to compare this figure with that of 1941 and 1942 but diligent education of the public will go a long way toward reducing the mortality of this disease in Kansas.

It is hoped that many more organizations throughout the state will sponsor cancer films and cancer talks to assist in this fine educational program that the Women's Field Army of Kansas is promoting.

SULFAMERAZINE

The frequent occurrence of crystalluria and hematuria in patients treated with sulfadiazine has stimulated the search for a chemotherapeutic agent which might lead to fewer renal complications. Sulfamerazine (2-sulfanilamido-4-methylpyrimidine) has recently been investigated beause of its greater solubility in water and urine.⁷

Several reports have been made concerning its use in a wide variety of human infections. 1,2,4,5,6 Sulfamerazine is more rapidly absorbed from the gastro-intestinal tract and is more slowly excreted in the urine than sulfadiazine. Therefore effective blood levels can be maintained with smaller doses given at longer intervals than with sulfadiazine. Apparently, an initial doze of four Gm. followed by one Gm. every eight hours is sufficient for all but the most severe infections in adults. Sulfamerazine appears to be fully as effective against infections due to pneumococci, meningococci, streptococci and B. coli. Sulfathiazole continues to be the most effective sulfonamide in staphylococcic infections.

The incidence of crystalluria, hematuria and blockage of the renal tubules, pelves and ureters due to sulfonamide crystals does not appear to be any less with sulfamerazine than with sulfadiazine. The most effective means of prevention of renal complications during sulfonamide therapy continues to be the maintenance of a urine output of at least 1,200 c.c. per day. Considerable evidence has accumulated that the maintenance of an alkaline urine

reduces the incidence of crystalluria during therapy with sulfamerazine and sulfadiazine. From fifteen to twenty Gm. of sodium bicarbonate per day will keep the urine continuously alkaline.3—Wendell H. Hall, M.D., Minnesota Medicine.

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"THE MASTER-WORD IN **MEDICINE**"

In one of Osler's matchless essays, he indicates that the master-word is work.

Perhaps the outstanding verification of this statement is to be found in his textbook The Principles and Practice of Medicine, the first edition of which came from the press in 1892. After more than forty years of preparation, this monumental work was prepared for publication in less than eighteen months.

For a long time the writing of this great book had been on Osler's mind, but he had "continually procrastinated on the plea that up to the fortieth year a man was fit for better things than textbooks." As he passed this age, he made the following confession: "I began to feel that the energy and persistence necessary for the asking were lacking." It is interesting to note that even Osler, with his knowledge and experience plus a God given facility for expression, needed a little prodding. But what is of greater importance is the fact that Osler's conscience was quite sensitive, he felt the sharp thrust of duty, marshalled the energy and mastered the difficult task. Relatively few doctors realize the full significance of this accomplishment

For approximately forty years, Watson's celebrated Practice had been the student's guide. Other texts had been published, but none fully met the need. It should be remembered that Osler's decision came when medical science was in a state of flux; in that notable decade of 1880 to 1890, which initiated a period of remarkable scientific development and which needed conservative consideration and sane recording. This was a critical period, and America was most fortunate in having a man so well fitted for the task. Harvey Cushing said, "He was, all things considered, extraordinarily well equipped to undertake the task. The one 'weakness' which has been mentioned proved in a curious way, as will be seen, an unexpected and most important service to medicine in general. For it led, in an indirect way, to the rescue of the hospital from its financial embarrassment after the Baltimore fire in 1903; to the establishment of the Rockefeller Institute a few years later; and, finally, to the incalculable benefit to humanity which the General Education Board has rendered with Mr. Rockefeller's money, owing to its interest in the prevention and cure of disease. Indeed, the present position of his colleague Welch, as Director of the Institute of Hygiene, is remotely due to the fact that Osler set himself thirty years before to write a textbook of Medicine, and, as Falconer Madan said years later, 'succeeded in making a scientific treatise literature."

Every student and every doctor, who consults this great textbook, should know what Fielding H. Garrison thought of its illustrious author. "When he came to die, Osler was, in a very real sense, the greatest physician of our time. He was one of Nature's chosen. Good looks, distinction, blithe, benignant manners, a sunbright personality, radiant with kind feeling and good will toward his fellow men, an Apollian poise, swiftness and surety of thought and speech, every gift of the Gods was his; and to these were added careful training, unsurpassed clinical ability, the widest knowledge of his subject, the deepest interest in everything human, and a serene hold upon his fellows that was as a seal set upon them. His enthusiasm for his calling was boundless. As Hare says, 'Osler went into the post-mortem room with the joyous demeanor of the youthful Sophocles leading the chorus of victory after the battle of Salamis.' All young English and American physicians who have followed the science and arts of medicine in this spirit have been pupils of Osler.' His writings have been aptly described as belonging to the true 'literature of power.'"

Eighteen years ago, Garrison said "Osler's Principles and Practice of Medicine is the best English textbook on th subject in our time."—The Journal of the Oklahoma State Medical Association.

TUBERCULOSIS CONTROL

HEMORRHAGE IN PULMONARY TUBERCULOSIS

Pulmonary hemorrhage is one of the most distressing phenomena encountered in medical practice. The patient is gravely alarmed and the physician is confronted by bleeding that comes from a point deep within a delicate organ enclosed in a rigid framework. To combat the bleeding there may be only slowly or doubtfully effective physiological mechanisms.

Psychological effects to one side, hemoptysis generally is indicative of serious pulmonary disease. It is recognized that unexplained blood-spitting must be considered due to tuberculosis until proved otherwise. However, occasional causes include such nontubercular diseases as bronchiectasis, bronchogenic carcinoma, lung abscess, rheumatic heart disease and various minor nose and throat affections. People apparently in good health and presenting negative physical signs and few or equivocal roentgen findings represent especially puzzling problems when they report having coughed up blood. In all cases it is essential that we exhaust every means at our disposal of tracking down the reason for obscure lung hemorrhage.

The causes of hemoptysis are still not clearly understood. Blame has been laid on deficiency in one of the factors concerned in blood coagulation, on tonic, nervous or endocrine factors, on erosion of a vessel wall by a tuberculous process, on rupture of a small aneurysm within a cavity. While the most serious hemorrhages occur in old, fibroulcerative tuberculosis, small or moderate hemoptyses may be seen in early disease, sometimes as the first recognizable symptom. Softening of a lesion or progression of an established process may be accompanied by hemorrhage.

Among 1,000 patients consecutively discharged from the Blue Ridge Sanatorium, Charlottesville, Virginia, only those were included in this study who gave a clear-cut history of spitting up one dram or more of blood, or who suffered a hemorrhage during their stay in the institution. "Streaking," "streaked sputum" and indefinite history of hemoptysis were excluded. In all, 905 cases of tuberculosis, made up of 424 males and 481 females, included 220 who had hemoptyses during the active phase of the disease. This is an incidence of 24.3 per cent, regard-

less of the duration of observation.

Some of the largest hemorrhages in this series occurred in a few patients showing bronchiectasis or rheumatic heart disease. Bogen, including instances of streaks and clots, found that over half of his hemoptysis cases expectorated less than two ounces of blood. The present study records 106 hemorrhages of stated amount, ranging from one dram to two quarts, the average being five ounces. This did not include repeated bleeding from the same individual on the same or subsequent days, since these were not felt to be distinct episodes, but more or less a continuation of the first. In approximately forty per cent of the cases the episode of hemoptysis was repeated at least once.

Hemorrhage was the presenting symptom, often the initial evidence of trouble, in sixty cases. Perhaps nothing drives a patient to seek medical advice faster than the expectoration of a single mouthful of blood, although twenty-three patients did nothing about their initial hemorrhage.

When the local physician was consulted by persons with hemorrhage in cases of previously undiagnosed tuberculosis seventy per cent were properly diagnosed, though it is estimated that in eighty-four per cent correct diagnoses could have been reached by further study.

Only forty-nine cases in the entire hemoptysis group failed to show a cavity on x-ray examination and of these eleven were found to be nontuberculous. No less than 83.4 per cent of the tuberculous cases with hemorrhage had a positive sputum. Of the 170 patients in this latter category, 159 had roent-genograms revealing consolidation, honey-combing, punching out or frank cavitation.

Correlation of hemoptysis with phsyical exertion, with direct chest trauma or with mechanical disturbance of the lung is possible in some cases, though hemorrhage may and often does appear when the patient is at rest, perhaps during sleep. In only twenty-eight cases in his study was there either a specific history of a precipitating factor or of its absence. In ten patients hemorrhage was related to one or more menstrual periods.

Among the graver consequences of pulmonary hemorrhage must be listed strangling and asphyxia from massive bleeding, fatal blood loss in the cachetic patient, and the commoner and everpresent danger that blood from a cavity which is generating a positive sputum will spread the infection to other parts of the lungs, giving rise to an acute tuberculous bronchopneumonia or a massive caseous pneumonia. Obviously, repeated episodes of blood-spitting multiply the chances for such complications to occur.

SUMMARY AND CONCLUSIONS:

- 1. In a study of 1,000 sanatorium tuberculosis patients it was found that hemorrhages occurred in 24.3 per cent of them.
- 2. The average size of hemorrhage was five ounces. Forty per cent of hemorrhages were eventually repeated.
- 3. In sixty patients, the first remarkable symptom was hemoptysis.
- 4. Seventy per cent of cases with a history of hemorrhage before diagnosis were properly diagnosed by the local physician, when he was consulted. However, thirteen per cent were misdiagnosed.
- 5. Most tuberculous patients who hemorrhage have cavitation visible on x-ray examination; 83.4 per cent of this series had a positive sputum.
- 6. Trauma to the chest, strenuous exercise, mechanical disturbance of the lungs and, in females, the mentrual period are definite precipitating factors.
- 7. Small hemorrhages often occur from early lesions at the height of the catarrhal and toxemic symptoms which probably signify softening. These are not usually serious and may, in the long run, be beneficial if they call attention to an undiagnosed tuberculosis. However, larger hemorrhages which occur in chronic ulcerative tuberculosis, while rarely immediately fatal, are accompanied by many unpleasant and dangerous possibilities. Of the twelve deaths which occurred in the sanatorium after hemoptysis, it is felt that five were directly or indirectly the result of the hemorrhage.—Hemorrhage in Pulmonary Tuberculosis, George R. Minor, M. D., American Review of Tuberculosis, August, 1943.

A death rate of 10.4 per 1,000 population in 1942, first year of American participation in World War II, was the lowest on record, the Census Bureau reports. The 1941 rate was 10.5.

Although there were increases in the three leading causes—heart disease, cancer and cerebral hemorrhage—sharp reductions were recorded in the rates for pneumonia and influenza and for automobile accidents.

The 10 leading causes together with comparative rates per 100,000 population were:

1942	1941
Heart diseases295.2	290.2
Cancer and other malignant tumors122.1	120.2
Cerebral hemorrhage	89.1
Kidney diseases 72.4	75.1
Pneumonia and influenza 55.7	63.9
Tuberculosis 43.1	44.5
Premature birth	25.1
Diabetes	25.5
Automobile accidents	30.0
Syphilis	13.3
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War casualties abroad were included in computing the death rates only in cases where the bodies were returned to this country.—Ohio State Medical Journal.

MEN IN SERVICE

From Major Alfred H. Hinshaw formerly of Kansas City we have the following "Please change my address on the Journal from 265th Station Hospital, Fort Snelling to 340 Station Hospital at Camp Ellis, Illinois."

Lt. William Spencer Fast of Atchison has been transfered from the Station Hospital at Fort Riley to Camp Carson, Colorado.

"Somewhere in Sardinia" Capt. E. Wray Enders of Lawrence, sends us a V-Mail letter to change his Journal address.

War Department orders published under the date of December 28 list the following doctors as promoted in rank: Dr. Cecil Edward Petterson of Norton from captain to major and Dr. Clarence Robert Schmidt of Halstead from captain to major. Dr. Lee A. Rook of Kansas City was promoted from lieutenant to captain.

Major Farris D. Evans was in Conway Springs on leave for the holidays, from Camp Chaffee, Fort Smith, Arkansas. He is the chief surgeon at the station hospital.

Major R. O. Garlinghouse, son of Dr. and Mrs. O. L. Garlinghouse of Iola, home from Africa, was interviewed in a Kansas City Times article. Major Garlinghouse says: "The need for amputation in the African campaign, in which American soldiers were thrown up against a maze of land mines and booby traps besides the other hazards of warfare, developed in remarkably few cases." He credits much of the saving to the use of sulfa drugs and early surgical attention. The unit which Major Garlinghouse was with was at the Kasserine Pass, where the Americans suffered their first setback of the campaign.

Dr. R. L. Gench, for several years in Fort Scott and more recently in Springfield, Illinois, who is now serving somewhere in New Guinea has been promoted from the rank of captain to that of major.

Capt. J. H. Bena, of Pittsburg, a flight surgeon stationed somewhere in North Africa, has been promoted to the rank of major according to recent announcements.

Dr. J. B. Carter of Wilson, State Senator from that district has been commissioned as a lieutenant colonel and reported for duty in the Army Medical Corps at Jefferson Barracks, Missouri, recently.

From the Eudora paper we have the following news item: "Dr. Edgar Robinson and Dr. G. G. Robinson are in service, one with the Navy, a lieutenant, and the other the Army, a captain, both graduates of the University of Kansas School of Medicine."

Dr. Leon W. Zimmerman of Liberal, now in the Pacific area has been promoted from the rank of lieutenant to that of captain.

Major R. L. Drake of Wichita was home recently on furlough. He is being transfered from Pando, Colorado, to the Schick General Hospital in Clinton, Iowa.

We just couldn't resist copying Lt. Comdr. James S. Hibbard's note from the January issue of the Sedgwick County Bulletin: "Dear Folks: Things are popping. Everybody is in good spirits and beating their guns. Saw Irish O'Donnell and he looks fat and satisfied. He should be, he has fifty white nurses on his ship. Also saw George Basham, who is returning to Great Lakes in excellent physical shape, considering eighteen months on the waves (and I don't mean enlisted). If you see Harold Palmer, and if you remember the crack in the bulletin-tell him that he doesn't know the right people, because their roast pig, with a chaser of bush wine, is delicious. Happy Voyage to the new members going into the service, and Smooth Sailing to you poor chaps at home."

The Sedgwick County Bulletin has this to say from Major Wayne C. Bartlet of Wichita: "We are now located quite comfortably in Nissen huts with lights, water and stoves. In addition we have steel cots with straw mattresses to sleep upon which makes us feel like we are living in the 'lap of luxury.' I expect to spend a day in London soon—will see some shows and shop a little."

Capt. C. D. Kosar of Concordia has been promoted to the rank of major. He is stationed at Camp Hulen, Texas.

Graduation exercises were held at the School of Aviation Medicine, Randolph Field, Texas on October 7 for those who had completed the work as aviation medical examiners. Kansas men listed were as follows: Capt. William C. Fairbrother of Madison and Capt. Joseph H. Johnson of El Dorado.

Col. Edgar Erskine Hume, formerly Commander of Winter General Hospital in Topeka, has been appointed regional civil affairs officer for the Allied Military Government in Naples, Italy.

Major Parker C. Hardin, a North Carolina surgeon, formerly an Arkansas City member of the Society, is the author of a leter from the South Pacific which is published in the January, 1944 issue of Readers Digest. The first paragraph of Major Hardin's letter is one we hope all our members on the home-front will read and take-heed: "At last I am actually starting a long overdue letter to you, to thank you for your generous ones to me. You know, letters are what keep the soldiers overseas going." The rest of his letter is a vivid description of the American soldier in action and he adds "I know that the American soldier has a native strength, ingenuity, courage, cheerfulness, stamina, pride in his comrades, a wisecracking, carefree spirit, and the undying determination to see this job

through to the end." Take time to read his letter, it is a vivid description of life in the Medical Corps of the present

Dr. Kenneth R. Hunter of Lebo, now in North Africa, has been promoted to the rank of captain. From a recent letter published in the Lebo Enterprise we read: "Weather here is quite mild, no frost although the nights are very cool. Rain has sort of let up a bit now and that makes it a lot more pleasant. Farmers are sowing grain and plowing the vineyard. The orange season is about to set in in earnest. Standard price is about ten francs per kilowhich means twenty cents for two and two tenths pounds, really amounts to about a nickel each for the larger oranges. All soldiers are catching up on eating them. There are also lots of tangerines while the olives are about picked now. Life in camp is very much the same except that there are a lot of new faces. Of the twenty officers that came overseas with this outfit only seven of us are still with it."

The Origin of the Caduceus. From as far back as Greek antiquity, and even in Biblical times, the snake has been used as a symbol of medicine and health. Presumably it was because the principle of life was represented by the serpent with its ability periodically to cast off its skin and apparently renew its youth. Accordingly, tamed snakes were used in the temples of Aesculapius for their psychic effect and also to lick wounds of the patients. Aesculapius, the Grecian god of medicine, is always represented as carrying a heavy, rough staff with a single serpent entwined around it—the staff for walking and the serpent as a symbol of medical knowledge or healing powers.

The winged caduceus used today as the emblem of the medical profession is a light wand with a pair of wings at the top and having two snakes entwined about the wand. It was originally the wand of Mercury, messenger of the Gods, and later symbolized the peaceful conduction of business—the mercantile world as opposed to the military. A somewhat similar form of this caduceus was also used as the staff of Hermes, who was god of many things, such as the wind and air, as well as robbers, thieves and traitors, and guide of souls to Hades. Some have facetiously suggested that from this latter duty of Hermes the caduceus came to symbolize the medical profession.

Just exactly how the winged caduceus, which has no legendary association with medicine, came to represent the profession is not known. It is thought, however, that certain medical printers used it as a part of their frontispieces to show the unity between medicine and letters as indicated by the two entwined snakes. From this it was probably misrepresented as being an emblem of medicine and later incorporated on the insignia of the United States Army Medical Corps—its misuse being practically assured from then on.

No matter how widespread its use, however, the winged caduceus with two entwined snakes is actually not a symbol of the medical profession. The only true emblem is the rough staff with a single serpent, the staff of Aesculapius, god of medicine.—Arnold, H. L., Serpent-Emblems of Medicine, Journal of the Michigan Medical Society.

NEWS NOTES

ANNUAL DUES

Dues for the year 1944 are now due and payable to the secretary of the county society to which you belong.

Secretaries are reminded that checks for membership dues must come through the secretaries and not directly from the members to the central office. It is helpful if the membership reports are filled out completely as to new officers, delegates to the state meeting and all information about active members and those in service. If additional membership report blanks are needed they may be obtanied by writing to the central office.

NEW FOURTH DISTRICT COUNCILOR

Dr. Frank Foncannon of Emporia was elected as Councilor of the Fourth District, including Wabaunsee, Shawnee, Coffey, Morris, Osage, Lyon and Chase Counties, at a meeting of the Council held in Topeka on January 9.

Dr. Foncannon was elected to fill the unexpired term of office of Dr. Philip Morgan of Emporia who recently went into the services of the Army as a major and is now stationed at Kelly Field, Texas.

POSTERS

The posters "Your Doctor and the War" which were made up and mailed by the Kansas Medical Society recently for use in doctors' offices and hospitals have elicited considerable comment. There are still a number of these posters on hand which will be sent to anyone requesting them. If your poster was broken beyond repair in mailing or if you would like an additional poster mail your request to the central office, 406 Columbian Bldg. Also if you think some local defense office would care for one of the posters please advise us.

AGAIN THE BLUE CROSS

The letter from Thomas Parran, Surgeon General of the United States Public Health Service to Dr. C. Rufus Rorem, Director of the Hospital Service Plan Commission of the American Hospital Association which was published in the January issue of Hospitals is of great interest to the profession, and is, therefore, for your information copied in full below:

"The program of the American Hospital Association in bringing hospital service to the American people through the Blue Cross plans, in my opinion, has been one of the significant developments of the past ten years in the field of health care. With a total enrollment of over 13,000,000 participants and prospects of increased enrollment in the future, the Blue Cross plans should play an important part in the future evolution of national health services.

"Your officers recently suggested that the voluntary movement for hospital and medical protection would be encouraged by official endorsement and cooperation on the part of the federal government. In order to guide us in the consideration of methods by which adequate health services may be made more widely available, we are con-

sidering making a special study of the administrative problems, community and professional relationships, and public health potentialities of voluntary health insurance organizations.

"The purpose of this letter is to ask whether the American Hospital Association would like to have the United States Public Health Service undertake such a study insofar as it would relate to the Blue Cross plans, and whether the commission and the Blue Cross plans would wish to cooperate in such an undertaking.

"At your convenience I should appreciate your views on the general suggestions contained in this letter."

CHANGES IN KANSAS E.M.I.C. PROGRAM

Dr. F. C. Beelman, secretary of the Kansas State Board of Health, recently released the following information relative to financial changes in the Kansas Emergency Management and Infant Care program for servicemen's dependents, which it is believed will be of great interest to the profession who are participating in the Kansas program:

Fee for complete maternity care has been raised from \$35 to \$50, effective with applications dated December 4, 1943, and later. Earlier applications will be completed at the lower rates in effect at the date when application was made.

REMUNERATION UNDER NEW FEES EFFECTIVE FOR APPLICATIONS OF DECEMBER 4, 1943, AND LATER

Medical-Obstetric:

a. Prenatal Care: To obtain the full fee of \$15.00 at least seven (7) visits or examinations of the patient must be made, after date of authorization. If fewer than seven prenatal examinations are made during the period of authorization, the fee will be reduced by \$2.00 for each visit less than seven, and if no prenatal examinations are made, \$15.00 will be deducted from the total fee. Conversely, if prenatal care alone is rendered, the physician will be paid up to \$15.00 for the total prenatal care at \$3.00 for the first, and \$2.00 for each of six (6) additional visits.

b. Delivery: Delivery and care of infant for first two weeks of life, \$32.00. Delivery and post-natal care with postpartum examination at about six weeks after delivery, \$35.00. If post-partum examination at six weeks or thereabout is not recorded, a reduction in the amount of \$3.00 will be made from the total fee.

c. Miscellaneous: When pregnancy terminates in spontaneous abortion, without operation, \$15.00. Therapeutic abortions or spontaneous abortions requiring operation, \$35.00. Ectopic pregnancy, and laparotomies, by attending physician, for complete care, \$50.00. Major surgery in amended program, maximum, \$50.00.

Bedside Nursing Care: For home deliveries, on recommendation of the attending physician, a registered nurse may be authorized to assist the physician in the delivery. The physician must be present for the second and third stages of labor and shall be assured of the satisfactory condition of the patient before leaving. The nurse is not permitted to make internal examinations. Following delivery this nurse may make daily calls, on an hourly basis, to care for mother and infant, giving professional nursing care for a period of ten days, or, on recommendation of the physician further care for a total maximum of two weeks. The nurse will be paid at the prevailing local rate. These

services should be authorized in advance by an application by the physician to the State Department of Health.

Pediatric Care: The amendment also includes the following additional pediatric care: Where no official facilities exist for well-child supervision, the state department will furnish biologics and pay the physician at the rate of \$1.00 per procedure for immunizing infants (under one year of age) of servicemen, against diphtheria-tetanus, whooping cough, and smallpox. Application should be made in advance of any care given. Authorization of the mother's care does not provide for care of the infant beyond the first two weeks, and an application should always be made when the infant needs care of any nature after it is two weeks old. Three doses of the immunizing agent are recommended for diphtheria immunization and the same number for whooping cough.

The sick infant is to be cared for at the previous rate. For circumcision, application (on the regular application Form M-1) should always be made before the service is rendered, or immediately afterward.

Note: The above fees are effective only for applications made on and after December 4, 1943. Earlier applications will be completed at the lower rate in effect at the time application was made.

At the meeting of the Technical Advisory Committee on December 20, 1943, the following action was taken:

11 tay with pathology requiring second picture,	
maximum	10.00
X-ray treatment of thymus	5.00
X-ray treatment, maximum	10.00
X-ray treatment of chest, (maternity) not in this pro	gram.
Major surgery coming under this program, maximum	50.00

Important: Payment cannot be expected for medical or hospital services which the wife or infant has had before application is made.

ADDITIONAL NOTES

Be sure all visits and services rendered after date of authorization are listed on the final report blank, Form M-3.

When an application has been signed by patient and physician, the dates should approximate and it should always be mailed promptly.

Any recommendations you have that will increase the efficiency of this program for the patient, the physician, or the Board of Health will be appreciated.

AMERICAN COLLEGE OF SURGEONS ANNOUNCES FELLOWS

The office of the American College of Surgeons under the date of December 24 announced that the following Kansas physicians have been accepted as fellows of the American College of Surgeons in 1943: Dr. Stephen S. Ellis of Coffeyville, Dr. Maurice V. Laing of Kansas City, Dr. Robert E. Pfuetze of Topeka and Dr. William S. Walsh of Halstead.

At the present time Dr. Ellis, Dr. Laing, and Dr. Walsh all have the rank of captain and are serving in the United States Army.

BRITISH PSYCHIATRIC FILMS AVAILABLE TO PROFESSION

A recent communication from the British Consulate in Kansas City, Missouri has requested that the Journal publish the following information, which it is believed will be of interest to those sponsoring scientific programs:

"The film 'Psychiatry in Action' is available for showing and if you have not seen this film it occurred to me that you might be interested in showing it to your faculty.

"The film, which was made at the Millhead Emergency Hospital under the supervision of Dr. Walter Maclay, who is at present in the United States, illustrates the warrime application of psychiatry to neuroses, both in servicemen and civilians. It is not a film which can be expected to teach the expert anything new about psychiatry theory, but to those familiar with the subject, it provides information as to the methods which are actually in practice, and so is of interest to the expert as well as to those with a moderate knowledge of the subject.

"The film may be rented for a nominal fee, fifty cents for the first reel and twenty-five cents for each additional reel for showing. Perhaps I ought to mention that the films are distributed by the British Government and carries out in the United States functions similar to those carried out by the O. W. I. in Great Britain.

"It might be well to have about two weeks advance notice so that there will be no question of securing the film for the date wanted."

Address your communication in regard to renting the films to: Reginald Davidson, Vice-Consul, British Consulate, Kansas City, 6, Missouri.

QUESTIONNAIRE ON POST GRADUATE WORK

A recent questionaire has been mailed to the physicians of Kansas to ascertain the needs and desires of Kansas doctors for further post graduate study along various lines. The quesionaire was sent out from the office of Mr. Harold Ingham, of the University of Kansas Extension Department at Lawrence.

The post graduate work in the state has been under the supervision of the University of Kansas School of Medicine, the Kansas State Board of Health and the Kansas Medical Society. The bulletin announced that the following courses had been suggested for future study: venereal diseases, cardiac disorders, pediatrics, obstetrics, clinical pathology, gastro-intestinal diseases and neurology, physical medicine and geriatrics. It is hoped that the questionaires will be completely and promptly filled in and returned to Mr. Ingham's office in order that further plans for post graduate study may be made.

PNEUMONIA CONTROL

Dr. F. C. Beelman, Secretary of the Kansas State Board of Health issued a bulletin in December in regard to the pneumonia control program for indigents in the state. In summarization the following hospitals and departments in the towns of Kansas have been consigned sulfonamide drugs for the use of physicians as needed for the treatment of such patients.

Wichita: Sedgwick County Health Department; St. Francis Hospital; Wesley Hospital.

Kansas City: Bethany Hospital; Providence Hospial; St. Margarets Hospital.



HOWD YOU LIKE A POSTCARD FROM BERLIN?

How much would it be worth? How much would a picture post card of a smiling Yank, walking down Unter den Linden be worth to you?

Would it be worth an extra hundred dollars in War Bonds to you? Would you help get our men set for the big push that will make such a thing possible?

You can help...and you can help shorten the War, too. With an extra War Bond now!

Now's the time to dig deep. Now's the time to get 'em the guns and the tanks that'll help save soldiers' lives—and get this war over!

Get an extra War Bond now!

Lets all BACK THE ATTACK!



THE KANSAS MEDICAL SOCIETY

Salina: Asbury Protestant Hospital; St. John's Hospital.

Goodland: Boothroy Hospital. Beloit: Community Hospital. Seneca: Seneca Hospital.

Clay Center: Clay Center Municipal Hospital.

Hutchinson: Grace Hospital. Horton: Horton Hospital. El Dorado: Lattimore Laboratories.

Lawrence: Lawrence Memorial Hospital; Douglas Coun-

ty Health Department.

Independence: Independence Mercy Hospital.

Emporia: Mid-West Laboratories; Newman Memorial

Hospital.

Pratt: Pratt County Health Department. Pittsburg: Mt. Carmel Hospital.

Hays: St. Anthony Hospital.
Dodge City: St. Anthony Hospital.
Topeka: St. Francis Hospital.
Concordia: St. Joseph Hospital.
Manhattan: St. Mary's Hospital.
Neodesha: Wilson County Hospital.

Sabetha: St: Anthony Murdock Memorial Hospital. Winfield: William Newton Memorial Hospital.

The Board of Health has advised that the following procedure should be used by physicians in obtaining the benefits of the pneumonia control program for their indigent patients.

"It is requested that all cases of pneumonia be typed. The sputum should be collected at the time or before drug administration. Tests will be authorized during the period when the patient is receiving specific treatment, as follows:

- Typing of Sputum (including typing of other body fluids or exudates). If pneumococci are not present, an attempt to identify the predominating organism will be made.
- 2. Blood Culture.
- 3. Blood Counts.
 - (a) A complete hemogram at the first examination.
 - (b) Hemoglobin determinations and leukocyte counts (or differential counts) every 48 hours.
 - (c) Erythrocyte counts and differential counts when indicated by significant reductions in the hemoglobin and leukocytes, respectively.
- 4 Urinalyses.
 - (a) A complete urinalysis at the first examination.
 - (b) Examination for blood every 48 hours, and more complete analyses if indicated or requested.
- 5. Blood Sulfonamide Level Determinations.

The fee schedule is as follows:

Typing	
(1) Neufeld	.\$1.00
(2) Mouse	2.00
Complete blood count	. 2.00
(Red, white, differential, hemoglobin)	
Complete Urinalysis	. 1.00
Blood concentration for sulfonamides	2.00
Blood culture	1.00
White count	1.00
Hemoglobin	50
Maximum amount allowed for laboratory work	
for any case	.10.00

Typing Sera: For several years the State Board of Health has been furnishing free of charge all typing sera. Since only a few laboratories reported the use of typing serum in connection with the Pneumonia Control Program the past year it has been decided to not furnish the typing sera unless the laboratories agree to type the sputum. The State

Board of Health desires each case typed for scientific data as to type of pneumococcus prevalent in Kansas. Furthermore it should be realized all cases of pneumonia do not respond to sulfonamide treatment and then therapeutic serum must be used. If you will use the typing sera it will be furnished.

Sulfonamides: Each station will be furnished a supply of sulfonamides, such as:

Sulfathiazole Sulfadiazine

Therapeutic Serum: This will not be stocked in any of the stations but all available types can be obtained by calling the Division of Public Health Laboratories, Kansas State Board of Health, Topeka, giving the name of patient, the type and amount of serum desired. This serum is furnished free for only those patients qualifying under the Pneumonia Control Program.

Blood Culture Outfits: So few laboratories made blood cultures on their pneumonia patients that the blood culture outfits will not be furnished unless requested.

Sulfonamides—Standards: Will be furnished to all laboratories upon request.

Laboratory Manual: Laboratory methods on the Pneumonia Control Program have been prepared and it is desired that these be followed so all work will be uniform. If you do not have a copy write for one.

The Kansas State Board of Health will pay for the laboratory services rendered for the indigent patients for whom the State Board of Health has received complete case records. In order to obtain the benefits of this program and receive payment, each patient must have a set of four cards complete in every detail giving the history of his case, as follows:

Case Report Card No. 1—The case report card is filled in by the physician and signed to show the outcome of the case. The principal reason for this card is to show how much drugs have been used on the patient. The amount of serum used on the indigent patient must also be stated on this card.

Service Request Form No. 2—Before any drugs are released, this card should be signed by the doctor showing that the patient is medically indigent.

Materials Issued Card No. 3—This card is filled in by the person in charge of the therapeutic materials. When a doctor requests certain drugs, the nurse fills in this card and the doctor signs the card before the drugs are released.

Report of Laboratory Examinations No. 4—This card is filled in by the laboratory making the examinations. From this card the vouchers are written to pay for all the laboratory services rendered.

POSTGRADUATE COURSE ON VENEREAL DISEASE

Postgraduate courses on venereal diseases have been arranged by the University of Kansas School of Medicine, the Kansas Sate Board of Health and the Kansas Medical Society to be held from February 1 to 17 in the following towns in Kansas:

February 1-2 Public Health Center (619 Ann Street) Kansas City.

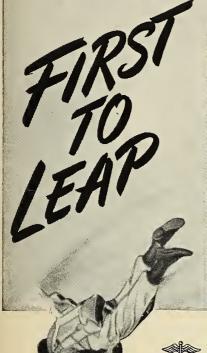
February 3-4 U.S.O. Room, Parsons.

February 5-6 Hotel Lassen, Wichita.

February 7-8 Wiley Tea Room, Hutchinson.

February 9-10 Lora Locke Hotel, Dodge City.







"Ready!" the pilot warns...Five tense minutes to go... the men "hook up" for the last brief check...

then the paradoctor's command: "Stand to the door!" But it is he who leads them off... first overside... first to face the unknown perils that lie below.

Courageous as he is versatile, the war doctor fulfills long, tough missions without thought of rest. When it's time to relax, he keenly appreciates the pleasure of a good smoke ... Camel most likely, the favorite of the armed forces*... for sheer mildness, friendly taste.

Make it your pleasure to remember those you know in the services. Send them cartons of Camels...often!

1st in the Service

*With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)



Camel—costlier tobaccos

New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

February 12-13 County Medical Society, Victory Life Bldg., Topeka.

February 14-15 Community Hospital, Beloit. February 16-17 Casa Bonita Cafe, Salina.

The faculty for the post graduate clinic will be: Dr. Percy Starr Pelouze, assistant professor of urology of the University of Pennsylvania, consultant urologist to Delaware County Hospital, special consultant to the United States Public Health Service and a member of the Board of Directors of the Neisserian Medical Society; and Dr. John Philip Berger of Wichita, former instrucor in Dermatology and Syphilology of the University of Michigan School of Medicine, now serving as an assistant to Dr. Udo J. Wile, head of the department and medical director of the Division of Venereal Disease Control of the United States Pubic Health Service.

The program for the series of meetings is scheduled as follows:

7:30 p. m.—Diagnosis of Gonorrhea—Dr. Pelouze; Diagnosis and Epidemiology of Syphilis—Dr. Berger.

9:00 a. m.—Pathology and Complications of Syphilis—Dr. Berger; Gonorrhea—Progress of the Disease—Dr. Pelouze.

1:15 p. m.—Therapy of Syphilis; Newer Concepts of Treatment—Dr. Berger; Gonorrhea—Management, including Chemotherapy—Dr. Pelouze.

The registration is limited to fifty in smaller centers and applications should be forwarded immediately to insure a place in the class group. A fee of \$3.00 will be charged to cover partial cost of the program and remittance of the fee should accompany the application. Arrangements are being made at all centers except Kansas City for a dinner meeting at 6:15 to open the first session. Registration blanks may be secured by writing to the University Extension Division, University of Kansas, Lawrence, Kansas.

RADIO PROGRAM RESUMED

The National Broadcasting Company and the American Medical Association will again sponsor the medical radio series, formerly "Doctors at Work" and now "Doctors at War," the first program of which was heard on January 8, 1944. The broadcast will be given on Saturday afternoon at 4:00 central standard time.

Permission for this year's broadcasts was granted by the Medical Department of the United States Army and the Bureau of Medicine and Surgery of the United States Navy and doctors in service will participate in the programs. The medical departments of both branches of the service will assist in the technical preparation of the broadcasts.

ARTICLE BRIEFED IN CONSUMERS' RESEARCH BULLETIN

A paragraph on the article "Effect of Sulfonamide Therapy on the Common Cold" by Lt. A. J. Kauvar and Lt. Col. Frank R. Mount of the Station Hospital at Fort Riley, which was published in the September Journal, was published in the Consumer Research Bulletin for December 1943, in the department entitled "Consumer's Observation Post."

The Bulletin in briefing the article says: "Sulfonamide drugs have been greeted with such acclaim by the lay press that the average person is apt to expect magical results from their use, particularly in treatment of the common cold. In a recent issue of the Journal of the Kansas Medical Society, Lt. A. J. Kauvar and Lt. Col. Frank R. Mount of the Army Medical Corps carried on a clinical study of the problem which showed no evidence that treatment with sulfonamides influenced the course of the disease or prevented complications. There was, on the other hand, real evidence to show that secondary complications were more frequent and more severe when sulfa drugs were administered than in cases where they were omitted. Consumers will be wise to refrain from indulging in self-medication with these drugs. They have unpleasant after effects, and may sometimes cause very serious or even fatal illness on their own account; thus they should be used only on prescription of a competent physician."

BLIND PROGRAM

Dr. W. W. Reed, state supervising ophthalmologist for the Kansas State Board of Social Welfare, recently issued the following report pertaining to examination and treatment furnished under the Kansas blind program as of December 31, 1943:

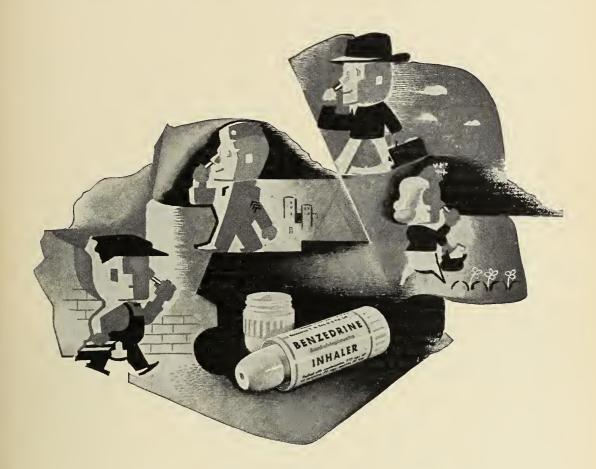
PROGRESS REPORT "Eye Examinations Dec. 1943 To Date "Aid to the Blind" Applicants 2820 2104 13 243 4924 48 Re-Examinations — Approved 26 Ineligible 3 74 597 Treatment Applicants 17 7 Re-Examinations 24 24 5545 Dec. 1943 To Date Recommendations for Treatment: 92 26 New Cases 8 118 1337 Cases Under Treatment . ..120 Completed Treatment Cases: Little, or no improvement
in vision 5
Less: Re-Opened Cases -4 35 298 Sufficient improvement in vision to remove client from "A,B," category A.B." category ______10 Less: Re-Opened Cases _____0 10 69 512 11 104 870 "Prevention of Blindness" Dec. 1943 To Date Recommndations for Treatment Cases Under Treatment Completed Treatment Cases: Vision lost in spite of treatment (client comes within definition of blindness) 12 Vision maintained or improved with treatment (vision better than 20/200) 44 Less: Re-Opened Cases-0 -16 6 484

There are one and one-half times as many deaths from tuberculosis among men as among women. The preponderance of deaths among men is in the older age groups, the reverse is true among women.—Mary Dempsey, Nat'l Tuber. Assn.

490



that the physician may overlook the fact that it is, first and foremost, a highly effective therapeutic agent.



Benzedrine Inhaler

In a Modern Plastic Tube



Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 250 mg.; oil of lavender, 75 mg.; and menthol, 12.5 mg. Benzedrine Is S.K.F.'s trademark, Reg. U. S. Pat. Off., for their Inhaler and their brand of racemic amphetamine.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

COUNTY SOCIETIES

The Bourbon County Medical Society held a meeting in Fort Scott on October 20. Dr. H. L. Hiebert, Director of Tuberculosis Control of the Kansas State Board of Health was the guest speaker.

The Clay County Medical Society were entertained with a Thanksgiving dinner at the home of the president, Dr. T. C. Kimble, in Miltonvale on November 17. Dr. C. W. Bale of Clay Center conducted an eye symposium, assisted by Dr. J. B. Stoll, Dr. F. R. Croson and Dr. F. C. Shepard of Clay Center.

The Commanche County Medical Society and the Kansas Crippled Children's Commission held a crippled children's clinic in Coldwater on December 7. Dr. A. E. Bence of Wichita assisted the local physicians in the clinic.

At a meeting of the Cowley County Medical Society held in Winfield on November 1, Dr. Harold Jones of Winfield was the speaker. The society decided to organize a speakers bureau.

At a meeting of the Crawford County Medical Society held in December the following officers were elected: Dr. E. C. McDonald of Pittsburg as President; Dr. D. B. Mc-Kee of McCune as Vice-President; and Dr. L. E. Strode of Girard as Secretary-Treasurer.

The Douglas County Medical Society elected the following as officers for the new year: Dr. R. B. Hutchinson as President; Dr. L. K. Zimmer as Vice-President; Dr. Fred Isaacs as Secretary and Dr. E. M. Owen as Treasurer. Dr. Zimmer, Dr. R. H. Edmiston and Dr. E. D. Liddy as members of the Board of Censors, and Dr. H. L. Chambers and Dr. H. T. Jones as Delegates.

At the Harvey County Medical Society meeting held in Newton on December 6 the following were elected to office for the coming year: Dr. T. L. Foster of Halstead as President; Dr. H. E. Morgan of Newton as Vice-President; and Dr. A. G. Isaac of Newton as Secretary-Treasurer.

The members of the Labette County Medical Society were the guests of the staff of the Kansas Ordnance Plant at Parsons on November 25. After the dinner, which was served at the plant cafeteria, members of the staff of the plant hospital held a symposium on "Toxemias Relative to War Plants."

The Linn County Medical Society elected officers at its meeting held in Mound City on December 22. Dr. L. D. Mills of Mound City was elected President; and Dr. J. R. Shumway of Pleasanton was elected Secretary-Treasurer.

At the December 1 meeting of the Marion County Medical Society the following officers were elected for 1944: Dr. H. F. Janzen of Hillsboro as President; Dr. O. C. McCandless of Marion as Vice-President; and Dr. R. C. Smith

CLASSIFIED ADVERTISEMENTS

FOR SALE—Office equipment of retiring physician engaged in general practice including complete line of instruments, instrument tables (2), sterilizer, anesthesia table, sterile cabinets, irregator stand, centrifuge. Everything in the best of condition. Write C-O-6—The Journal.

FOR SALE—Ten volume set, loose leaf, Tice "Practice of Medicine." Up-to-date. Address Journal C-O-13.

FOR SALE—Office equipment of retiring physician engaged in general practice. Located in good college town of fifteen thousand, in Kansas. Address Journal C-O-X.

FOR SALE—Large assortment general surgical and bone instruments. Cold quartz and carbon lamps. Bone engine, splints, etc., all about as good as new and prices about 15 per cent of cash. Tell me your needs and let me quote price. C-O-12—Journal office.

FOR SALE—Office equipment of late physician, including complete line of instruments, tables, cabinets (2), Burdick Ultra Violet Lamps (2), B quarts lamps (2), Spencer Microscope, walnut examining table and Victor X-Ray. Write Journal C-O-14.

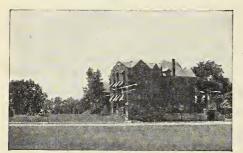
FOR SALE—Two used examination tables, and three wood, leather-padded, treatment benches. No reasonable offer refused, write: C-O-5.

FOR SALE—Surgical instruments for abdominal and perineal surgery—including retractors, uternine, intestinal clamps—towel forceps also outfit for tonsil and adenoid work. All in good condition at a big reduction. For information write Journal C-O-10.

FOR SALE—Because of health must relinquish good practice and lease of small modern Kansas hospital. Good opportunity with no overhead expense. Address Journal C-O-15.

Alcohol — Morphine — Barbital

Addictions Successfully Treated Since 1897 by the Methods of Dr. B. B. Ralph



Write for descriptive booklet

THE RALPH SANITARIUM Ralph Emerson Duncan, M.D.

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"How much do you smoke?"

is only part of the question!

Far more important than "How many cigarettes do you smoke?" may be the question, "How irritating is your cigarette?"

RECOGNIZED LABORATORY TESTS* SHOWED THAT THE IRRITANT QUALITY IN THE SMOKE OF FOUR OTHER LEADING BRANDS AVERAGED MORE THAN THREE TIMES THE STRIKINGLY CONTRASTED PHILIP MORRIS.

The possibility of irritation from smoking can be minimized by suggesting a change to Philip Morris.

PHILIP MORRIS

Philip Morris & Company, Ltd., Inc., 119 Fifth Avenue, New York



*Facts from: Proc. Soc. Exp. Biol. & Med., 1934, 32, 241-245; N. Y. State Jrnl. of Med. Vol. 35, No. 11,599; Arch. of Otolaryngology, Mar. 1936, Vol. 23, No. 3,306

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend-Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

of Marion and Dr. A. K. Ratzlaff of Goessel were elected to the Board of Censors and Dr. G. J. Goodsheller of Marion was elected as Delegate.

The annual banquet of the Montgomery County Medical Society was held in Coffeyville on December 9. Dr. C. C. Nesselrode of Kansas City was the guest speaker. A business meeting preceded the banquet at which the following officers were elected: Dr. J. H. Low of Coffeyville was elected as President; Dr. James Hughbanks of Independence as Vice-President; Dr. C. O. Shepard of Independence as Secretary and Dr. G. C. Bates of Independence as Treasurer.

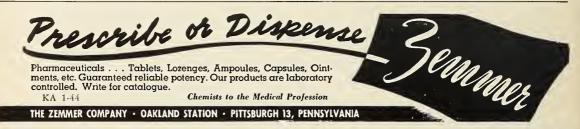
The Rice County Medical Society held a meeting in Sterling on December 16. Dr. J. L. Lattimore of Topeka, President, was the guest speaker.

At the December 9 meeting of the Saline County Medical Society Dr. E. G. Padfield was elected President; Dr. Harold Neptune was elected Vice-President; Dr. Earl L.

Vermillion as Secretary and Dr. E. M. Sutton as Treasurer. The next meeting will be held on January 13.

The Shawnee County Medical Society at its meeting held on December 6, elected Dr. Paul E. Belknap as President; Dr. C. K. Schaffer as President-Elect; Dr. W. J. Walker as Vice-President, Dr. J. H. O'Connell as Treasurer; and Dr. L. A. Smith as Secretary. Dr. Robert T. McElvenney of Chicago, a member of the faculty of Northwestern University School of Medicine spoke on "Freezing Limbs in Preparation for Surgery."

The Sedgwick County Medical Society held a dinner meeting on January 4 at the Hotel Lassen in Wichita. Dr. J. L. Lattimore of Topeka discussed "This Year for the State and Local Society"; Dr. F. L. Loveland of Topeka discussed "This Year for Kansas Procurement and Assignment" and Dr. Arthur W. Fegtly of Wichita the new President of that society gave the "Presidents Address." Other officers of the society are as follows: Dr. J. S. Reifsneider is Vice-President; Dr. L. K. Nix is Secretary and Dr. A. L. Ashmore is Treasurer.





Kansas' Newest and Most

FERTILE FRONTIER

Promises Economic Growth for Small Communities

Through 400 years, Kansas has been a land of fertile frontiers. Its pastures provided the beginning of a great livestock industry. The plowed soil later produced great crops for food and feed. Still later, exploitation of the minerals under the soil produced another source of wealth . . . and the growth of industry, the mills, packing plants, aircraft factories, refineries, foundries and thousands of other types of endeavor, form the fourth frontier.

Today, Kansas faces a new, greater frontier that combines the best of all the others. It is a frontier of chemistry and science, the production of goods through the combination of Kansas farm and mineral products.

It also is a frontier that can be interpreted in terms of the growth of the smaller Kansas communities. It CAN be—if those communities plan NOW.

Efforts made today will mean that Your town will have something with which to attract returning servicemen and returning war workers. It can mean an increased population . . . and that means a greater farm produce market with greater wealth for the entire area.

It will pay to know today what you want to do tomorrow. Contact the Kansas Industrial Development Commission for information on what your town can do about making plans for tomorrow.







The Kansas Industrial Development Commission

801 HARRISON

TOPEKA, KANSAS

The Washington County Medical Society held a farewell dinner meeting for Dr. D. A. Bitzer of Washington, on December 14. Dr. Bitzer had orders to report for Navy service in December.

The Wilson County Medical Society held a dinner in Neodesha on November 12, with the wives of the members as guests. Two former members of the society, Dr. Lynn Beal and Dr. W. T. Rich, both lieutenants in the Navy, were home on leave and gave short talks at the dinner.

The Wyandotte County Medical Society met in the Chamber of Commerce rooms on December 21. At a business meeting the following were elected as officers: Dr. John H. Luke as President; Dr. G. M. Tice as Vice-President; Dr. W. J. Feehan was re-elected as Secretary and Dr. Hughes W. Day was re-elected as Treasurer.

MEMBERS

Dr. Paul H. Lorhan of Kansas City is the author of an article on "Continuous Caudal Anesthesia in Obstetrics" in the November issue of the Journal of the Missouri Medical Association, which he presented at the 86th annual session of the Missouri society in St. Louis, Missouri.

The Kansas City Southwest Clinical Society bulletin for November and December, 1943, published an article entitled "Kansas Method for Medical Care" by Dr. Forrest L. Loveland of Topeka.

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The same service and cooperation from Quinton-Duffens that you received in 1943. We have our stocks and personel in good shape and anticipate no serious difficulty in serving you well this next year.

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Your Local Independent Wholesaler

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AS EVER GROWING numbers of cases yield to liver therapy, pernicious anemia emerges from among the one-time "incurables." Today, men and women who must, can face this condition with justifiable optimism—for there is hope. . . .

And so the laboring physician has two allies—a proven medicinal, and the fighting spirit of his patient.

When his choice of a liver product falls upon Purified Solution of Liver, Smith-Dorsey, he may count a third ally—the dependability of the maker. For Smith-Dorsey's product comes from laborations capably staffed . . . equipped to the most modern specifications . . . geared to the production of a strictly standarized medicinal.

In that especially critical anemia case—as in all the others—you need a product of the caliber of

Purified Solution of

Liver-SMITH-DORSEY

Supplied in the following dosage forms: 1 cc. ampoules and 10 cc. and 30 cc. ampoule vials, each containing 10 U.S.P. Injectable Units per cc.

The SMITH-DORSEY COMPANY LINCOLN NEBRASKA

Manufacturers of Pharmaceuticals to the Medical Profession Since 1908.

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An abstract of the article "Treatment of Nail Puncture Wounds of the Feet" by Dr. M. A. Walker which was published in the November 1942 issue of the Journal was published in the November 1943 issue of Southern Medicine and Surgery. The same issue of the Journal abstracted the article by Dr. J. B. Nanninga of Newton entitled "Bacillary Dysentery Epidemic" originally published in the October 1943 Kansas Journal.

Dr. H. R. Goshorn, formerly of Arcadia and more recently of Lamar, Missouri has opened an office in Alton.

Dr. P. E. Theis, formerly of Spearville, has located in Jetmore.

Dr. R. H. Blender of Mankato has accepted a position in Seattle, Washington as a staff member of a clinic in that city.

The Kansas Business Magazine for December, 1943, contained an article on the Parsons State Hospital which carried a note on Dr. James T. Naramore, superintendent

and Dr. Earle O. Stevenson, assistant superintendent of the hospital.

Dr. Lattimore's Presidents Page was reprinted in the October 1943 issue of the Wisconsin Medical Journal in the column called "News of Neighbors."

BOOK NOOK

I do not want you to read these books because they are old, but because they are good.—Sir Norman Moore.

BOOKS RECEIVED

OPERATIVE ORTHOPEDICS-Willis C. Campbell, M. D., Memphis, Tennessee. Published by the C. V. Mosby Company of St. Louis. Priced at \$12.50. This volume of 1154 pages, beautifully illustrated has particularly interesting and fine drawings of operatic procedure in orthopedics. The book is a valuable addition to any surgical library,

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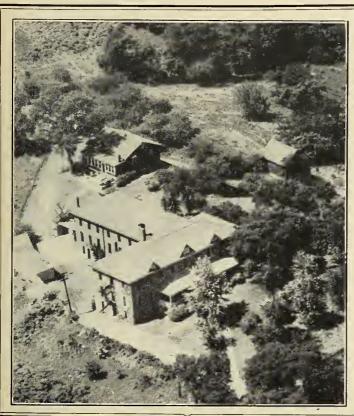
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Of especial interest to the reviewer was the material on protruding intervetrable disks showing techcnic of removing these, which was easily understood and the authors comment on the fact that in post mortum examinations they have found many patients with broken disks having healed and the patient lived without pain.—L.M.T.

PENICILLIN, and Other Antibiotics Produced by Microorganisms, An Annotated Bibliography — Prepared by the Library Staff of E. R. Squibb and Sons, New York. The little booklet was published in July, 1943, and according to the foreword is designed to present the literature regarding antibiotics from the discovery of penicillin by Fleming in 1929 to May, 1943. Most of the abstracts were prepared by the library staff of E. R. Squibb & Sons with some abstracts from other sources included, these relating chiefly to the chemistry of the long-known antibiotics. According to the booklet it is being distributed in anticipation of the time when penicillin will be available to all medical practice, that they may have an opportunity to post themselves on the preliminary investigation. Copies are available gratis to physicians. Address your request to

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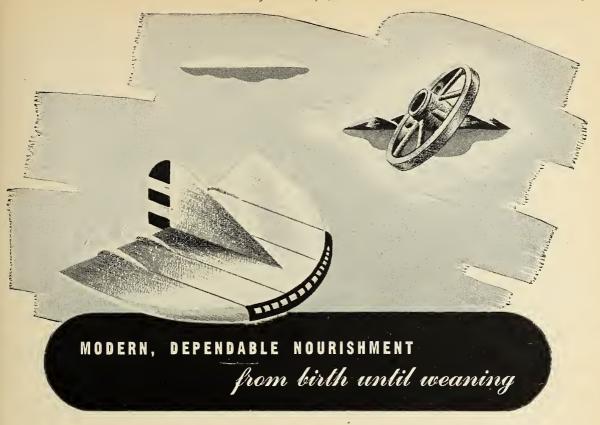
The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

THE UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

JANUARY, 1944

31



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BOOKS RECEIVED

The American Medical Association has recently published reprints from articles printed in Hygeia on the following subjects: Syphilis-The Great Tragedian by Green Williams; Health and Fitness at Fifty by Roger I. Lee; Choosing Medicine as a Career; Psoriasis; and The Melancholy Colon by Greer Williams. The booklets may be secured by writing to the Bureau of Health Education of the American Medical Association, 535 North Dearborn Street, Chicago, Illinois. Price of the booklets is ten cents each and quantity price may be secured by writing to the Bureau.

UROLOGY IN GENERAL PRACTICE-Nelse F. Ockerblad, B.S., M.D., F.A.C.S., Professer of Clinical Urology of the University of Kansas School of Medicine, Senior Attending Urologist to St. Luke's Hospital, consulting Urologist to the Children's Mercy Hospital of Kansas City, Missouri; Diplomate of the American Board of Urology and Hjalmar E. Carlson, BS., A.M., M.D., F.A.C.S., Instructor in Urology of the University of Kansas School of Medicine; attending Urologist to St. Luke's Hospital and Trinity Hospital of Kansas City, Missouri; Diplomate of the American Board of Urology. Published by the Year Book Publishers, Inc., 304 South Dearborn Street, Chicago, Illinois. The book contains 383 pages, illustrated and is priced at \$4.00.

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ANNOUNCEMENTS

The American College of Surgeons has announced that it plans to hold 22 one-day sessions in twenty-two cities of the United States and Canada during March and April 1944. Each meeting will open at 8:30 a. m. with the showing of official United States Army and Navy films on medical and surgical subjects, such as evacuation of the wounded, fractures, bomb blasts, burns, and treatment of wounds. From 11:30 to noon representatives of the Public Health Service will report on measures for the control of endemic and epidemic diseases. At the luncheon conference the Procurement and Assignment questions will be discussed. The afternoon will be taken up with various scientific discussions and panel meetings.

A meeting will be held in Tulsa, Oklahoma at the Mayo Hotel on Tuesday, April 4, one in Denver at the Cosmopolitan Hotel on Friday, April 7, and in Chicago at the Stevens on Monday, March 6, 1944.

"Tha American Urological Association offers an annual award 'not to exceed \$500' for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made.

"Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the Secretary, for full particulars. The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, June 19-22, 1944 at the Hotel Jefferson, in St. Louis, Missouri. Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1944."

The National Society for the Prevention of Blindness has announced that a prize of \$250 will be awarded for the most original paper adding to the present knowledge about medical treatment of non-congestive glaucoma. Papers should be in the office of the Society, 1790 Broadway, New York City, by September, 1944.

MEDICAL ASSISTANTS MEETINGS

The Sedgwick County Medical Assistants Society held a Christmas meeting on December 14 in Wichita. The new officers of the society which were installed at that time are as follows: Zura Crockett as President; Helen Hall as Vice-President; Opal Kaminke as Treasurer; and Martha Heitz as Secretary. The new board members are as follows: Thelma Gelbach, Charlotte Parrish, Pauline Brown, Dorothy Hindman and Velma Lauderbach. The next meeting will be held in Wichita on January 20, 1944.

The Shawnee County Medical Assistants Society held a meeting in Topeka on January 10. Capt. Margaret Kennedy, head nurse of Winter General Hospital was the speaker. Captain Kennedy, who has been in the service of the United States Army for twenty-five years had spent some of that time in Hawaii and the Philippine Islands and told of the life there. She was transferred to Topeka from Fort Williams, Maine.

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AUXILIARY

PRESIDENT'S MESSAGE

It is the wish of your State President that no Auxiliary neglects to take advantage of what the "Bureau of Health Education," directed by W. W. Bauer, has to offer. This bureau has been established in order to help the work of the Auxiliaries. Are you preparing a paper or a program? There is available to you a set of eighty Hygeia clipping loan collections on popular topics ranging from anesthesia to youth. No charge is made for these except return postage. There is a radio library available for use in projects approved by county societies. Ask for lists of talks and order sheets. Also two series of transcribed radio programs can be had in the same way. "American Medicine Serves the World at War"-six fifteen minute transcriptions, "Before the Doctor Comes"-sixteen fifteen minute transcriptions. This Bureau of Health Education has been established for the Auxiliary, let us make use

The Hygeia contest closes January 31. We hope some of the four hundred dollars in prize money will come to Kansas. Even if the contest is over, still keep Hygeia in mind and whenever possible present it as an authentic and reliable health magazine.

It is suggested that one meeting each year be turned over to the Legislative Chairman. Forums or round table discussions may be used for this program, its aim being an informed and effective membership. As Auxiliary members we should be interested in all federal and state bills as they are presented.

Sincerely,

Mrs. E. E. Tippin

YEAR BOOKS

If you have not received your Kansas State Medical Auxiliary Year Book please notify Mrs. E. R. Millis, 1517 Minnesota Ave., Kansas City, Kansas.

WOMEN'S AUXILIARY NEWS

The Women's Auxiliary to the Saline County Medical Society entertained with a luncheon at the Trianon in Salina on December 9 in honor of Mrs. E. E. Tippin of Wichita, State President of the Auxiliary. She gave a report of the National Board meeting which was held in Chicago in November. Mr. Oliver Ebel, executive secretary of the Sedgwick County Medical Society spoke on "Medical Headlines and Oddities." Musical numbers were furnished by two service men from Camp Phillips. Mrs. Hugh Hope of Hunter, a State Chairman, and Mrs. W. W. Weltmer of Beloit, former State Treasurer, were out-of-town guests for the luncheon.

The Women's Auxiliary to the Rice County Medical Society were hostesses at a buffer supper for the Rice County Society members on December 23 in Sterling.

The Women's Auxiliary to the Shawnee County Medical Society entertained at the home of Mrs. Floyd Beelman in Topeka with a desert luncheon on January 10.

Mrs. R. M. Sorenson was the assisting hostess. Dr. H. L. Hiebert, Director of the Division of Tuberculosis Control of the Kansas State Board of Health discussed "Modern Attacks of Tuberculosis."

The Wyandotte County Auxiliary entertained with a one o'clock luncheon at the home of Mrs. J. E. Barker on January 14. Assisting hostesses were: Mrs. Fred Morley, Mrs. H. L. Regier, Mrs. W. J. Feehan, Mrs. I. A. Jones, Mrs. Harry King, Mrs. E. A. Reeves, Sr., Mrs. A. J. Rettenmaier and Mrs. Thomas Richmond. Mrs. J. F. Hassig was chairman in charge of the luncheon. Dr. W. H. Pickett of the department of health spoke on "Medicine Up to Date."

AN AUXILIARY MEMBER SHOULD KNOW

A medical auxiliary serves the medical profession and through it the public. Such service is satisfactory, because it is unselfish. An auxiliary is always organized with the permission of the medical society and should have an adviser or advisory committee to direct it. The auxiliary should make an annual report to its society and undertake no new project without its approval.

The principal functions of an auxiliary are: Health education, public relations, legislation (reserve force), philan-

thropy, and social.

The laity requires education, but it should be given through the medical profession, so there may be rational influence over the thinking and activities of the public in health problems. The most important objectives of an auxiliary are to direct public thinking and actions in channels the medical profession suggests and to extend authentic information on health. We support an organization only when we are a member and understand the tasks and objectives and how to accomplish them. An auxiliary member, therefore, should attend as many meetings as possible so that she may:

- 1 Understand the purpose and objectives of her auxiliary.
- Receive the particular charge given by local, state, and national organization.
- 3. Receive instruction in how to fulfill that charge.
- 4. Become adequately informed about:
 - (a) Personal and community hygiene.
 - (b) Administration of local, state, and national health.
 - (c) Medical and health laws, local, state, and national.
 - (d) The health of her community.
 - (e) Communicable diseases; their prevention and control.
 - (f) Her health in relation to her community.
 - (g) General problems of health that all should know.
 - (h) Approved educational material; where to obtain it.
 - (i) The development of the medical arts.
 - (j) Why the A. M. A. urges the promotion of Hygeia; how it is done.
 - (k) Health legislation the medical society supports; why; how the auxiliary acts as a reserve force; what the individual may do.
 - Philanthropic work related to the medical profession; service by her auxiliary; what her auxiliary is doing; why.
 - (m) What lay organizations are doing in her community to promote better health.

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THE JOURNAL

of the

KANSAS MEDICAL SOCIETY

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Volume XLV

FEBRUARY, 1944

Number 2

MEDICAL PROBLEMS IN THE PACIFIC*

Gerald W. Smith

Captain, (MC), U. S. Navy

The medical problems encountered in waging a war with a people separated from us by thousands of miles, and who are acclimatized to the regions where battles must be fought, are enormous. Much of the fighting necessarily has to be done in areas where tropical diseases are hyperendemic. greatly increases our difficulties.

Our armed forces are strategically distributed to hundreds of bases in the Pacific, some large, some small. To keep men in physical readiness, each base must be initially supplied and maintained with adequate medical facilities and personnel according to its particular needs. Each naval ship must have a medical unit able to cope with mass casualties which may occur among her own crew or from crews of nearby sunken or badly damaged ships. The Navy Medical Service's aim is to keep as many men at as many guns as much of the time as possible. This requires a flexible medical organization which is able to meet the ever-changing requirements developing in this highly mechanized and widely distributed war.

The purpose of this paper is to set forth some notable medical achievements which have been developed since Pearl Harbor, and to point out the tremendous medical problems which still face us. They need not all be solved in order for us to win this present war, but by solving some of them much human suffering may be prevented, lives may be saved and the war brought to an earlier victorious conclusion.

PRE PEARL HARBOR

For many years the military medical services have been occupied with maintaining the health of their peace-time personnel, studying sanitation and hy-

giene, advancing and applying mass preventive medicine, developing efficient medical units on ships and shore stations, and training medical personnel in various specialties. In time of war, the regular corps must be able to indoctrinate thousands of reserve medical officers in service methods. We, of the regular service, have kept the medical administration machine well oiled; now the reserve officers have stepped in and are able to carry on. Too much credit cannot be given these men who have voluntarily given up so much to enter the service. The excellent way in which they have done their work and fitted into the pattern is attested by every one who has had the good fortune to be associated with them. Their excellent work with the Pearl Harbor casualties from the very beginning has continued on board cruisers, destroyers, carriers, and in the jungles of the tropics.

Medical department activities, at the time of Pearl Harbor, were at least as well prepared, perhaps better so, than other departments. Their record at Pearl Harbor in successfully treating thousands of casualties clearly indicates this. For months before Pearl Harbor, work went along at feverish haste to have all officers and men thoroughly trained in first aid procedures, attain more medical supplies and equipment aboard ships, and have them dispersed widely so that one bomb explosion would not leave the ship depleted of valuable medical equipment and personnel.

Reports were being received from other countries regarding numerous combat medical problems, and a few of us had the opportunity to discuss with medical officers of other navies who had seen considerable naval action, the conditions under which they were forced to work and the difficulties which they encountered. We had seen plenty of practice firing, but it was difficult to visualize the havoc one twelveinch shell or torpedo hit may cause, and the amount of confusion which may arise when such an event occurs. Talking with these medical officers, who had survived the real experiences of having most of their supplies and personnel lost, and who were unabe to reach much of their remaining equipment due

^{*} The William W. Root Lecture, of the Alpha Omega Alpha Honorary Medical Society, presented at the University of Kansas School of Medicine, Kansas City, Kansas, December 17, 1943.

NOTE—The opinions and assertions contained herein are those of the author and are not to be construed as those of the Navy or of the Naval Service at large.

to fire and flooding, if it did nothing else, impressed us with the importance of having abundant medical supplies aboard and dispersed to hundreds of places on the ship.

Most of us have some conception of the tremendous task which lies ahead of us in the Pacific. It is a challenge to the medical profession at home and in the field, and so far they have both measured up to it, but we must not be complacent. Much remains to be done.

ADVANCES IN MEDICINE SINCE PEARL HARBOR

That troops are able to live under combat conditions on islands in the Pacific, and remain physically fit aboard hundreds of ships, many of which remain at sea for months at a time, does not occur by chance. This has been achieved by a nation-wide mobilization of medical scientists who, by research and its application, have been able to make notable advances in surgery, chemotherapy and preventive medicine. Each one of these advances has its part to play in keeping the man behind the gun or, at least, in getting him back there sooner than would be otherwise possible.

Infection Now the Rare Occurrence: Infections following fragment or bullet wounds are now the rare occurrence. In the Civil War, it is estimated that fifty per cent of the wounded men died. In World War I, fifteen per cent of the wounded died. A large proportion of these deaths were the result of wound infection. In this war, due to the present method of treatment, only from two to three per cent of men with combat injuries die¹. The sulfa drugs have a large part to play in bringing about this re-Sulfanilamide used locally in duced mortality. wounds and sulfathiazole or sulfadiazine by mouth prevent infection complications in most instances. These drugs are proving of value in preventing one of the terible dangers in war, gas bacillus infection. It looks now as if the use of penicillin, which is effective against staphlococcus, may reduce the number of wound infections even further.

The Morphine Syrette: For reducing intense suffering of wounded men in the forward areas, nothing can replace morphine. Development of the morphine syrette began during the last war, but was found unsatisfactory because morphine sulfate was used instead of the more stable morphine tartrate. It was only a few years ago that production in quantity of this convenient and time-saving syrette began. Until the morphine syrette came into use, administering morphine was an awkward procedure for it usually entailed the use of heat, sterile water, a spoon, morphine tablet, syringe and needle, and a steady hand. This, of course, prevented its use by any one

other than a corpsman or medical officer, and meant that much suffering would be undergone by the wounded while awaiting medical assistance. On board combat ships, morphine syrettes may be found in hundreds of first aid boxes above and below the weather deck. All personnel are trained in its use. If life is to be saved during time of battle, it usually has to be saved by the man's own shipmates.

Value of Blood Plasma: Prior to Pearl Harbor, we were establishing blood banks aboard ship, making our own plasma and stowing it in refrigerators for the day when mass casualties might occur. Contamination of these units frequently occurred, and it was discontinued when dried plasma was finally produced and delivered in sufficient quantities. One of our greatest contributions to saving of life has been the provision of facilities for plasma transfusions on ships and in the foward battle areas, so that the wounded man may obtain it immediately. This has been made possible by blood donor centers. Now blood is collected, largely from civilians, processed, and forwarded to ships and field transfusion units which are attached to advanced medical units as far forward as the type of battle allows. With the accelerated tempo of war, more blood plasma will be needed.

Treatment of Burns: Following evacuation of most of the U. S. S. Lexington's crew to our cruiser, a large proportion of the wounded survivors were found to be suffering from second and third degree burns; many were in a state of shock². We had sufficient plasma on hand and antishock teams of corpsmen trained in its administration. One mess attendant with seventy-five per cent of his body surface burned, died within fifteen minutes after coming aboard, but undoubtedly many of these men owe their lives to their receiving plasma.

The treatment of burns remains a very controversial subject. When analyzed it is noted that there is no disagreement regarding the general treatment, but only as to which method of local treatment is best. It is easy to lose sight of the general picture at hand when a large number of burned men are in need of treatment. From sixty to seventy-five per cent of deaths from burns occur within the first forty-eight hours3. Initial shock must be treated in the accepted manner, in restoration of body heat, morphine for pain, and plasma intravenously to restore fluid loss. The patient may recover from primary shock, but after twenty-four hours, go into secondary shock due to further loss of fluids from increased permeability of blood vessels and exudation of burned areas. This results in increased hemo concentration with slowing of flow of blood. After forty-eight hours, and up to one hundred twenty

hours, the danger of toxemia and liver necrosis arises which may cause the patient's death. After one hundred twenty hours, death may ensue from sepsis or other complications.

The patient's general condition must be carefully evaluated and proper care given to get him over the constitutional effects of burn trauma. Various local therapies, such as tannic acid, triple dyes, paraffin, sulfa ointment, vasoline and pressure dressings assume only a secondary role in importance.

On board ship where one is likely to encounter mass casualties from burns, it is of vital importance to use a method of local treatment which is not time consuming. This is extremely important, and can only be fully appreciated by the physician under stress of battle, who has from forty to fifty severely burned men to care for all at once.

The exigencies of the moment prevent debridement. This procedure is not contraindicated in burns providing it can be done carefully under sterile conditions. But picture how long it would take to carefully debride forty cases. If debridement cannot be done, eschar solutions should not be used for fear of infection developing underneath. Also these patients will usually be transferred within a week to a hospital or base hospital, and moving them causes cracks to occur in the eschar with subsequent infection. Eschar solutions applies to face, hands, and genitalia are contraindicated due to tissue edema, constriction, diminished blood supply to part and resultant gangrene. The British Medical Service had so many such complications that eschar forms of treatment have largely been abandoned. Most of our medical officers afloat have discontinued their use. The local method of treatment for burns now generally used in the armed service, consists of no debridement or washing, application of sterile petrolatum or sulfa ointment, compression bandages over cotton waste, immobilization and rest of the affected part. Sulfadiazine is given by mouth and its blood level is kept between six and eight mgm. per one hundred c. c. Plastic surgery, if indicated, should be done as soon after the twelfth day as possible. This does not imply that other methods of local treatment will not produce just as good results. But for treatment of the burned man in the forward areas, this method seems most practical and is less time consuming than others.

On board ship, injuries from burns are incurred frequently. In one carrier action, the burn cases far outnumbered all other injuries. Even though naval ships are stripped to the bare essentials required for personal living comfort, fire may easily break out, and in a short time become a more serious problem than enemy firing. Just consider that fuel oil, high

octane gasoline and ammunition make up a great part of any combatant ship's load.

Flash burns, which are first and second degree burns, result from exploding shells or bombs. In our earlier naval actions, the men did not realize the importance of keeping all of their bodies covered even though they had been repeatedly warned. The lesson at Pearl Harbor had not been taken to heart. Men below deck thought it was not necessary to wear their heavy, hot, blue denim clothing, and as the result, many of them were seriously burned over areas where the skin was unprotected. In subsequent naval actions, however, there was no difficulty in keeping the men well protected with clothing. A new anti-flash burn ointment has now been developed which should reduce the number of these casualties and add to the comfort of the men stationed below deck.

Development of Mobile Hospital Units: For several years work has gone ahead in developing mobile hospital units. The first one was outfitted and sent to a base in the Carribean area. Valuable experience was gained regarding the choice of equipment, personnel needs, construction of buildings, supplying and maintaining a thousand-bed hospital unit in an area where nothing stood before. Problems of shipping and loading were solved. The difficult problems of water supply and its purification and softening, toilet facilities and disposal of waste, insect control, messing, berthing, laundry, building construction, light and power, refrigeration, were worked out satisfactorily, and it is well such lessons were learned4. Now many such hospital units are proving their worth in the Southwest Pacific Islands where they are located sufficiently close to the forward area to receive battle casualties by plane several hours after injury occurs. One such mobile hospital unit even before its completion began functioning and handling large scale casualties during and following the Pearl Harbor disaster. These mobile hospital units have been of exceptional value during the recent Solomon Island campaign.

Medical Departments Afloat: In comparing medical departments on board our naval ships with those of other navies, the contrast is striking. Our medical units are equivalent to small, modern hospitals. Operating rooms and equipment permit almost any type of surgery. Surgical beds for postoperative cases are provided. A laboratory where most diagnostic tests may be done by trained technicians is a part of every ship's medical unit. Ships are outfitted with comfortable wards, dispensary, pharmacy and ample surgical, medical and biological supplies. These supplies are dispersed to scores of first aid boxes, gun bags, battle lockers, and to several battle dressing

stations. Extensive damage may be done to the ship from fire, bombs or shells, and still sufficient medical equipment permits adequate treatment of the wounded⁵. These medical units, manned by welltrained personnel, are able to care for most injuries and illnesses until patients are returned to duty. Medical departments as found on our ships have a great part to keeping up morale, for all hands know that if injury or sickness befalls them, their chance of recovery is possibly as great on board as in their home town hospitals. The medical personnel of all types of combatant ships have had plenty of opportunity to demonstrate their worth. The accomplishments of the medical personnel of the cruisers U. S. S. Marblehead, Boise, Helena and San Francisco, to mention only a few, are outstanding.

Important Role of the Hospital Ship: Two hospital ships were in commission when war came. One of these ships was in Pearl Harbor during the attack. Fortunately she was not damaged for hundreds of wounded from stricken battleships were received. Her surgical and medical facilities made possible the saving of scores of lives and hastened return to duty of many wounded men. Subsequently this ship has made a remarkable record in the South Pacific. Her surgical service cared for over four thousand patients suffering from battle injuries.

Approximately two-thirds of these men were received from Guadalcanal, the rest from naval ships⁶. These wounded men were taken aboard from six hours to two weeks after injury, and they were transported to base hospitals. The marine casualties included many fragment wounds from shells and grenades, but more from bullets and bayonets, which indicates the intenseness of the fighting. Evacuees from ships were suffering from fragment wounds, compound fractures, and burns. Their method of treatment of wounds by light cleansing, local application of sulfathiazole, pressure dressing and immobilization, gave highly satisfactory results. Many of us on combatant ships found that application of plaster casts to large flesh wounds was more practical than were the dressings. This closed plaster method of treatment resulted in less transportation difficulties, less discomfort to patients and required less nursing hours per patient. Extensive debridement was found not only unnecessary, but contraindicated. Wounds were not closed unless they involved the face. Foreign bodies were removed when in joints, when infection had occurred or when pain persisted. The mortalty was .18 per cent among these casualties. This is an excellent record which clearly indicates that if the missile does not cause massive injuries which produces death within several hours,

the patient has an excellent chance of recovery, and return to duty.

The Value of Air Transportation: The magnificent work of the air transportation service in evacuating wounded men from forward areas to mobile or base hospitals in the rear in a matter of hours rather than days, has been an outstanding accomplishment. A medical officer accompanies the injured, and supportive therapy may be continued in transit. The many advantages to this method of transportation are obvious. However it cannot entirely replace other methods of evacuation. Occasionally air transportation is impossible because of inclement weather or due to enemy action. Nearly all types of cases have been found suitable for this mode of evacuation, though certain precautions must be taken. It is important that the altitude of a plane carrying a patient with head trauma or chest injury, be limited to three thousand feet. Subjecting a patient with a closed pneumothorax to a higher altitude may cause expansion of the pneumothorax with mediastinal shift and resultant anoxemia7. It is understood that the British are not transporting patients who have received severe abdominal injuries. They have made every effort to operate these cases within the first six hours after injury, even under unfavorable conditions in the forward areas, rather than subject the patient to air transportation or any other form of transportation. Refrigeration units are being installed in some planes to allow refrigeration of extremities of individuals in extreme pain or when amputation is necessary. In transit, the patient's limb is becoming anesthetized and he is able to make a comfortable trip. Refrigeration of the part not only allays pain but restricts bacterial growth, preserves tissue, improves circulation and brings about quicker healing.

Prevention of Epidemics: The great epidemic menaces of previous wars which have disseminated whole armies have been so far prevented during this war. Only cerebrospinal meningitis has reached epidemic proportions⁸. Its mortality has been from three to five per cent as compared to thirty to forty per cent formerly, due to sufadiazine therapy. In diseases where vaccines have been developed, such as typhoid, smallpox, typhus, yellow fever, tetanus, and cholera, their incidence is exceedingly low and deaths negligible. Only relatively few tetanus infections have occurred since all our troops have been receiving tetanus toxoid inoculation and booster injections prior to their entering combat areas.

Typhus fever, a disease whose globalendemic area exceeds even that of malaria, usually has a death rate of thirty per cent and is hyperendemic in areas where our troops undoubtedly will be fighting before the

end of the war. During the last war hostilities had to be discontinued in Serbia due to this disease. Between 1917 and 1922 an estimated ten million cases of typhus, resulting in approximately five million deaths, occurred in the area which extends southward from Poland through the Balkans into Iran and Egypt⁹.

Our troops receive three injections of typhus vaccine and booster injections when they reach endemic zones. The low incidence rate among our troops stationed in these areas indicates the vaccine's effectiveness. Formerly after delousing of clothing, reinfestation might occur immediately. Aerosol powders, sprays and ointments which are nontoxic have recently been developed which kill insects and eggs in clothing, and remain effective for ten days. This is a great advance towards control of yellow fever, malaria, typhus fever and other insect-born diseases.

Prevention of Injuries Due to Cold: In our recent Aleutian operations, a large proportion of our casualties resulted from injuries due to cold. Unfavorable conditions prevent elimination of these injuries, but the occurrence is less frequent since suitable clothing has been developed and all personnel thoroughly trained in prevention and first aid to these injuries. Cold injuries occur when body heat is not maintained or when blood circulation of the extremity is not adequate. The former is controlled by wearing of outer clothing made up of tightly woven or impervious material and inner garments of loose texture which hold air particles inside. When a garment becomes wet, its insulation effect is lost. Experimentation is continuing in developing a garment which will retard the rapid loss of body heat of the man immersed in near freezing water. Such a garment might allow him time to reach his life raft or rubber boat. Without such clothing protection, life cannot be sustained for more than a few minutes.

Last summer two men fell overboard from a ship in Aleutian waters. They were hauled out within eight minutes, but neither regained consciousness and both died within thirty minutes. Crews of our ships and planes operating in these areas are faced with this constant hazard.

Maintaining adequate blood supply to the part is a necessary factor in preventing cold injuries. An example of this type of injury is immersion foot, trench foot or frost bite¹⁰. These injuries are frequently seen in survivors who have existed for days in crowded conditions on rafts or who have stood for long periods in damp foxholes. Early symptoms are pain, swelling and bluish discoloration of the part. Treatment consists of elevating part to promote venous drainage and slowly raising the temperature. The old method of rubbing the swollen part vigor-

ously with snow is definitely contraindicated. Cold water may be used, but tepid or warm water will produce more injury. Even light cases of immersion foot or frost bite must be regarded as strictly stretcher cases. Blisters should not be punctured. Sulfanilamide is used locally, the part lightly dressed and kept at rest.

Blast Injuries: Considerable interest is being given to concussion blast injuries, which is not a new entity, for many casualties due to blast injury from high explosives were seen during the last war. Examination in these cases often revealed no external evidence of injury whatsoever. The term shellshock was first used for these cases, but later it became a diagnostic wastebasket and had no clearly defined meaning. Blast injuries, however, have a definite clinical and pathological picture. When a shell explodes, terrific gas pressure from one hundred to six hundred fifty tons per square inch is developed which blows the casing apart. The gas rushes out in a wave which consists of a single terrific pulse followed by a longer phase of suction¹¹. The terrific impact of the pressure wave ruptures particularly the victim's pulmonary structures. Clinically, the patient suffering from blast injury shows shock, dyspnoea, cyanosis, severe chest and abdominal pain with cough, hemoptysis and extreme restlessness. The initial shock is due to the injury, but later secondary shock may occur due to increase in intrapulmonary pressure.

If an individual is close enough to an exploding shell or bomb on board ship to receive concussion blast injury, he has little chance in escaping flying missiles and severe injury from being thrown against some object. During the Coral Sea engagement two cases of air blast injury were brought aboard our cruiser. They were in shock, hemorrhaging from mouth and nose and flash burned over all exposed areas. Treatment of initial shock was successful, but they remained irrational, had repeated convulsive seizures and assumed attitudes of decerebrate rigidity between seizures. Except for initial pulmonary hemorrhage, they presented the clinical picture of severe head trauma. They had spinal subarachnoid bleeding, and both had neurological findings indicating cortical damage. Any blast forceful enough to rupture pulmonary parenchyma will undoubtedly propel a man at tremendous force against some object, usually a bulkhead. An uncomplicated air blast injury case is seldom seen on a combat ship.

Immersion blast injuries from explosions in water have been reported for the first time during this war. Following the Battle of Midway, the men from the U. S. S. Hammann jumped overboard after their destroyer was hit by a torpedo. A few minutes later depth charges exploded resulting in death to a large percentage of the swimming men; some were over fifty yards away. Survivors who were fortunate enough to get on a raft and have their body out of water, were unaffected by this explosion. Others who were just half way on the raft when the explosion occurred, stated that their legs and genitalia felt as if they had been driven up through their shoulders. Men who were swimming on their backs were less affected by the explosion than those who were swimming on their stomachs¹². Men with their heads in the water when the explosion occurred became unconscious and drowned. Others pulled onto rafts were hemorrhaging from mouth, nose and rectum. Many of these men died before they could reach Pearl Harbor, and a number died from peritonitis after arriving. Autopsy findings showed petechial hemorrhages to brain, lungs and intestines. Some of the intestines were torn and shredded for six and eight inches. Treatment of blast injury must be symptomatic and prevention of water blast injuries can only come from development of heavy protective garments which cover the body. This garment has already been developed.

FUTURE NEEDS

While the achievements of the medical profession have been many, resulting in reduction in mortality, more rapid recoveries, lowering the incidence of numerous diseases and abolition of others, considerable remains to be accomplished before maximum effectiveness of our troops in the forward area is reached.

The Psychiatric Unfit: Psychiatric screening of draftees and recruits by psychiatrists at Induction Centers prior to their induction into the armed services is playing an important role in preventing but not eliminating many constitutionally inferior, emotionally unstable, mentally deficient, neurotic and psychotic individuals from entering the service. Further neuropsychiatric evaluation of men not rejected is made at various training centers with the purpose of early detection of men with psychiatric defects who would become a liability to the service through their inaptitude and inefficiency; or who, by breaking down at a critical moment, might seriously jeopardize the success of an entire command. It is necessary to eliminate the unfit recruit as quickly as possible. If this can be accomplished before he has been completely outfitted with clothing and trained, expense is avoided. Every day this man is allowed to remain in the service, the more difficult it becomes to establish a non-service connected origin to his disability, or at least in proving that his condition was not aggravated by service conditions.

These neuropsychiatric boards have been able to weed out many recruits with preclinical conditions

or personality defects which make them potential psychiatric casualties. It is hoped that this careful effort at elimination of the unfit will avoid a repetition of the bitter experiences of the last war, when approximately three-fifths of all American Expeditionary Force casualties were neuropsychiatric in nature¹³. The cost already to the Government by this group, a high proportion of which should have been eliminated before induction or shortly thereafter, amounts to well over one billion dollars, and the end is not in sight.

Psychiatric casualties are occurring in this war; however, not to the extent popularly believed. A review of hundreds of case histories of veterans of the last war indicates clearly that the diagnosis of neurasthenia, hysteria and "shellshock" was often made on any man who had a few vague but persistent complaints.

The terms "combat fatigue" and "operational fatigue" which carry with it no connotation of mental disease or of future recurrence, have been added to the U.S. Navy diagnostic nomenclature. The choice of "fatigue" diagnosis depends on whether the man has undergone combat experiences or only prolonged and arduous duty not involving actual combat¹⁴. The patient with combat fatigue will show physical and nervous exhaustion and experience nightmares wherein he reenacts in part or entirely the traumatic scene. On awakening, the effect of fear persists. Sudden loud noises during the day or night cause him to start suddenly and this reaction is associated with symptoms of anxiety. It has been found that men with combat fatigue are amenable to treatment; somatic diseases, especially malaria and dysentery with their associated exhaustion, are frequent concomitants in these cases. With subsidence of malaria or dysentery and improvement in their general condition, disappearance of all psychiatric symptoms often occur. By erroneously establishing a diagnosis of hysteria, neurasthenia, or war neurosis, these men would be invalided from the service to join the roles of hundreds of thousands of neuropsychiatric pensioners of the last war. Proper evaluation of their condition by trained psychiatrists in our base hospitals near the forward area prevents such diagnoses and waste of manpower. It has been found that psychotherapy, prolonged sedation and rest in a pleasant environment not too distant from the forward area result in most cases in their return to duty.

Men at sea do not usually become psychiatric casualties as frequently as soldiers or marines who are forced to remain in the forward area under fire day after day. A naval action seldom lasts for more than a few hours, at the most. Fear, which is a normal reaction in any man entering a battle, is dissipated as

it arises through close association of shipmates. No sudden quantity of fear will cause a mental breakdown in a normal individual who has not been previously storing it. However, when fear has been building up over a period of weeks or months without being allowed to escape in a normal manner, there is superimposed an inordinate amount of fear, a permanent psychiatric disability may be precipitated. Men on board ship are not subjected to long periods alone in foxholes, sentry duty in isolated spots where companionship is prevented and where apprehension and anxiety are likely to be more intense and of longer duration. Likewise, living conditions on board ship are better than can possibly be attained by troops in the field. For these reasons perhaps, no cases of combat fatigue or true neuropsychiatric states have come to my attention among men on our cruiser over a period of nearly a year of intensive operations in combat areas. Neither were these conditions observed among the survivors of the U.S.S. Lexington and the U.S.S. Yorktown.

Malaria: The greatest single problem facing the military medical services today is the control of malaria. The importance of this problem is not generally appreciated. There is no doubt that the length of the war in the Pacific will depend on the conquest of malaria. As operations become more extensive in the Southwest Pacific, and in the more heavily infested countries of Burma, India and Malay States, involving millions of our troops, loss of lives and tremendous numbers of men invalided from the combat areas may be expected. The post-war complication of this disease alone will be far reaching. Seventeen of our states have endemic malaria. The anopheline mosquito is a habitat of many more. The return of thousands of malaria infected men into these regions will unquestionably cause incidence of malaria to rise considerably. More virulent and therapy resistive plasmodia will be introduced into these localities. As many of these men are infected with malignant falciparum species, we may expect a large increase in the number of malignant malaria cases among civilians unless adequate steps are taken to prevent it, and the medical profession at large becomes more malaria conscious.

The symptomatology of malaria is not running true to textbook form due to mixed infections our men are developing and due to prolonged suppressive therapy. Those of us who are admitting men with obscure conditions to service hospitals, who have been in the Southwest Pacific even as long as a year ago, think of malaria immediately and attempt to rule it out. The bizarre atypical forms the disease now assumes approaches that of syphilis. Routine blood smears for plasmodia are being done on those

returned men just as it is the routine procedure to do a blood Kahn test.

Malaria, unfortunately, cannot be cured. We are as much in the dark as to how quinine acts on the parasite as we were forty years ago. The acute attack may be arrested with quinine or atabrine, but in all likelihood a relapse will occur. Each succeeding attack fortunately becomes less severe and less frequent unless reinfection occurs, until usually the patient is able to develop enough immunity to prevent the paroxysms.

The clinical results from small doses of quinine or atabrine have been better than when massive doses of these drugs are given. Plasmochin has not proved satisfactory, its dangers outweigh its possible advantages.

Progress has been made in prevention of malaria by educating the men and instructing them how to protect themselves from becoming infected. But the individual in a foxhole hours on end, remaining constantly alert to enemy attack, will not become impeded with mosquito nets or remember to rub insect repellent liquid over his exposed parts. His mind will be otherwise occupied.

The warfare against insects continues. A health bomb containing only five mgm. of the active principal of aerosol, the new phenomenal insecticide developed by the United States Department of Agriculure, when exploded will kill all insects in one thousand cubic feet of air space within three minutes¹⁵. New and more efficient mosquito bars are being issued. An odorless insect repellent when rubbed on the skin is effective from three to five hours.

Dysentery: Dysentery has been one of the greatest menaces to armies in the past, and during the last war thirty-eight thousand hospital admissions among men in the Army resulted from diarrheal disease.

There is no effective immunization for amoebic or bacillary dysentery. Lowering their incidence may be brought about by education of the men and establishing stringent sanitary measures as soon as landings are made. Sulfaquanadine and sulfasuxidine prove helpful in treatment of the bacillary form¹⁶.

Peptic Ulcer: Peptic ulcer, a psychosomatic entity, causes a good number of casualties. Men who have had peptic ulcers do badly on board ship or in the field. When conditions are at all difficult, these men seldom are able to make the necessary adjustment. Even when they are restricted to limited duty ashore, they frequently fail at that. Invariably, if the environment is not to their liking, a recurrence of symptoms appears necessitating their hospitalization.

The Allergic Individual: Asthma cases are constant problems aboard transports and in the field.

Many men have developed asthma on tropical islands who never previously had allergic difficulties. With these patients also their degree of symptoms is frequently in direct ratio to their distaste for the type of duty they have been assigned, and to their desire to continue doing their part in this war effort. They are sent out of the Pacific area to West Coast Hospitals. A greater proportion of them show no asthmatic symptoms on arrival, but they cannot be returned to the forward area. Limited duty is given them in most instances.

Manpower Loss From Filariasis: Filariasis has been contracted by a high proportion of troops in certain South Pacific areas necessitating their return to the States. This condition is self-limiting if re-infection is prevented. By the time these patients arrive on the West Coast they are usually symptom free and only rarely is filaria demonstrated in the blood or lymph glands. These men are never returned to an area where filariasis is endemic. The loss in manpower from this disease has been great, and continues to be the paramount health problem in this particular tropical area.

Today's Incurable Conditions: Our present means of prevention and treatment of arthritis, rheumatic fever, blood dyscrasias, cancer and the so-called degenerative diseases of advancing years have not prevented the loss to the service of thousands of men with these conditions. The incidence of rheumatic fever in the service is no greater than among the civilian population. Men who have a history of rheumatic fever do not do well in the service. Recurrences appear; often their condition becomes permanently aggravated and they become pensioners. Arthritis and arteriosclerosis account for many sick days. A high percentage of these cases are ultimately invalided from the service and require prolonged rehabilitation.

Venereal Disease Problem Far From Solved: Venereal disease is not only a medical problem, but an ethical and social one as well. It is approached by the services in an educational way, and by cooperation with local authorities and with the Public Health Department. Many men with gonorrhea are delayed in reaching forward areas because hospital treatment is required. Needed hospital beds have to be used in getting these refractory cases back to duty. Sulfa drugs, fever therapy and penicillin are reducing the sick day loss considerably. In the Navy during 1942, the incidence9 of venereal disease was thirty-three per one thousand as compared to seventy and twotenths during 1918. This is a considerable improvement, but the problem still remains with us.

CONCLUSION

The preceding conditions discussed are seriously

impeding our war effort not only because they cause trained and equipped men to be evacuated from forward areas necessitating replacements, but because these men frequently become prolonged hospital cases and never return to duty.

While medical achievements have kept pace with modern methods of warfare to such an extent that the noneffective personnel for physical reasons are less than in former wars, and deaths from combat injuries are far lower than ever before, yet, many disabling conditions lurk in the background, and remain a constant threat to our present maximum effort and future peace.

All these various problems may not be solved during this war or perhaps for years to come. However, many of them may be made less serious, and considerable manpower loss be prevented if medical officers keep in mind the paramount importance of preventing a disabling functional condition from arising in an injured or ill individual.

Again it is stressed that this may be achieved by treating a man's wounds or his physical or mental illness in or near the forward area where he remains in close contact with his own group of friends. Association with them or being in the same general area with them gives him a great incentive to return and take his place within his unit.

War is a grim business. It requires adequate, trained manpower. We must not allow the unnecessary loss of a single man. The most careful evaluation of every case prior to his transfer to a hospital in the States will benefit the individual, help preserve our present manpower and may reduce the coming post-war veteran compensation problems.

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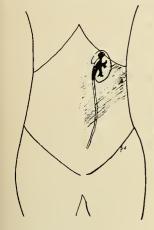
TUBERCULOSIS—A VISCERO UROLOGIC COMPLEX*

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A tubercular condition of the kidney may present diagnostic complications just as confusing as those of the gall bladder case reviewed in last month's issue of the Journal.

Tuberculosis of the urinary tract is often very difficult to determine in its early stages. In the absences of urinary tract complaints with painful symptoms in other areas, it is not uncommon to find that attention has been directed away from the primary seat of trouble for a considerable period of time.



F.31. BACKACHE THE
INITIAL SYMPTOM.
LITTLE GNAWING PAINS
AT FIRST, RADIATING
TO LEFT ABD.
NO RELIEF FROM ANY
MEDICATION IN 4-5 YRS.
NU CAUSE FOUND UNTIL..
UROLOGIC STUDY...
TBC. KIDNEY.

Fig I

In this instance (Fig. 1) little or no attention was directed to the urinary tract because her chief complaint was back pain and the urine findings were normal on routine examination.

The term 'normal' urine is used with reservations, for tubercule bacilli cannot be detected by a simple microscopic inspection of a droplet of urine.

In retrospect, it is plainly evident that a destructive process of the left kidney (Fig. 2) had been going on for some time before the patient began to lose weight and complain of frequent urinations, particularly at night.

During the four or five year period preceding complaints which drew attention to the urinary tract, various efforts were directed toward relief of the back pain. Attention was focused on the decoy while the destruction progressed.

It is sometimes difficult however, to see the forest on account of the trees. And, as has been said, if our



foresight were as good as our hindsight we could simplify many problems.

It has been pointed out repeatedly that detection of the tubercule bacilli may require considerable patience and perseverance. Intensive search of perfectly stained smears may need to be done repeatedly.

Even in a suspected case, it may be necessary to continue the search for some time before one can verify his suspicions, but such proof should be available before destruction reaches a stage comparable to the one shown in this instance. Undoubtedly showers of the organisms must have been present in the urine on various occasions before the final diagnosis was made in this case. Furthermore, the organisms were undoubtedly present before tubercules of the bladder developed which were manifestations of the spread of infection to that area causing frequency, urgency, and dysuria.

In the final analysis it may be said tuberculosis of the kidney progresses very insidiously. The organisms frequently escape detection, because attention is diverted by decoy symptoms or because proper search is not pursued, until the destructive process is full blown.

In this case the initial referred symptom was pain in the back and left side. In the next case it may be to some other area. Or, it may be some complaint other than pain. In any event consideration of the urologic tract as a source of trouble may simplify the diagnostic complex.

^{*} The second of a series prepared for the Journal of the Kansas Medical Society.

President's Page

To the Members of the Kansas Medical Society:

One of the most constant criticisms that is directed toward organized medicine is: "What have you done to combat the trend to socialization?"

Many attempts have been made and are being made to establish various programs that will satisfy certain groups, which are demanding what we called socialization. Actually these groups do not know exactly what they want. If they believe that medical service, or any other service, is going to be rendered to them without charge, they are wrong. The federal government does not offer such a proposal. What it does propose is a planned type of insurance covering illness and its attending expenses. Whether the medical profession likes it or not makes not the least bit of difference, for it is a trend of the people's thinking. I am convinced that the only way we can combat this entire federalization program is to offer the people various plans which will furnish these services at a fee that is comparable to the government charge. In that event, I feel that we could govern our own program, we could be our own administrators. If we, as a profession, refuse to establish these programs, spend our time in arguing over the minor details, insist that the good old times and ways of doing business must return, then we shall pay the penalty and lose our identity in a maze of governmental regulations and administration. In fact, we are already greatly socialized with a large number of physicians, such as full time employees, radioligists, pathologists, anesthetists, health officers and many others, working under a system that is comparable to socialization.

Most certainly I dislike to see socialization come. However, in my opinion it is coming, and if we are as smart as we should be, we will get in the driver's seat and manage our own business. The surest way for us to lose the battle is for the physicians in Kansas to refuse to do anything. There will be no perfect plan worked out, we will object to many of the inclusions, but let's be sensible and do the best under the existing conditions.

Sincerely,

President, The Kansas Medical Society

J. L. Lattimore W.

EDITORIAL

EXECUTIVE SECRETARY RESIGNS

In January 1944 the officers and members of the Society received the following letter of resignation from Mr. Robert Brooks, the executive secretary of the Society since October, 1942:

"Please accept this as my resignation as executive secretary of the Kansas Medical Society effective as of February 1 or at such time as a successor is elected.

"This is indeed a difficult severance to make but I believe that it is best for everyone. I want to thank each of you personally for the kind and helpful things that you have done for me during the last fifteen months. The Kansas Medical Society is very dear to my heart and I want you to know that I will always hold it in the highest esteem."

He has accepted a position as secretary of the Ottawa Chamber of Commerce.

Mr. Brooks succeeded Mr. Clarence Munns who was granted a leave of absence from the office in September, 1942, to enter the armed forces. Mr. Munns was the first executive secretary of the Society, being appointed to that newly created position in 1934. No executive secretary has been selected to replace Mr. Brooks but the council at its meeting held in Topeka on January 9 named Mrs. Margaret Foster of the central office as the acting executive secretary.

Mrs. Foster was originally employed in the central office in the spring of 1942 and in December of the same year assumed the position of secretary which she has held most efficiently through the introduction of a new executive secretary into the office, several changes in office personnel, an active legislative year, and additional duties of the central office on an accelerated war program. She will be remembered by those attending the Topeka state meeting for her capable handling of the minutes of the various business meetings. In the past years she has held several managerial positions in Kansas and California and the Society is most fortunate in having so capable a person to handle the executive office procedure until a permanent executive secretary can be secured.

ERTRON

As a result of the appearance in the November Reader's Digest of an article by Paul de Kruif on the use of ertron in arthritis, physicians will be asked about the value of the preparation by patients suffering from various forms of this affliction.

From the tone of the article the uninformed individual might be led to believe that here is the longsought solution of the arthrits problem. While it is true that the claim of 100 per cent cure is not made, the impression is given that here is a remedy overlooked by the profession in general, and it has been left to de Kruif to tell the world.

The makers of ertron claim that it is irradiated ergosterol specially prepared by a new electric process. It is put out in capsules each containing 50,000 U.S.P. units of Vitamin D. It was on the market as far back as 1935, and has been offered to the profession with most extravagant claims. Of late the literature sent the profession has been more insistent, and has been accompanied by reprints in proof of its value.

The use of Vitamin D in the treatment of arthritis is not new. Many physicians have used it and have used this special preparation known as ertron with indifferent results. As far back as 1937 the Council on Pharmacy and Chemistry investigated the preparation, although the manufacturers had not submitted it to the Council.

In their refusal in 1937 to accept ertron for inclusion in New and Non-Official Remedies, the Council called attention to the danger of relying too much on improvement in subjective symptoms as reported by patients in estimating the value of a remedy used in a disease subject to remissions. At that time the critical examination of the reports of the value of Vitamin D in this treatment of chronic arthritis revealed little to warrant the belief that the benefificial effects claimed were specific and the Council deprecated the unwarranted exploitation of erton to the profession. There is room for considerable doubt whether more recent experience with the drug warrants any change in its sattus.—Minnesota Medicine.

MEDICAL EDUCATIONAL PROGRAM IN WARTIME

Dr. Willard C. Rappleye of New York, chairman of the executive council of the Association of American Medical Colleges discussed the effects to date of the wartime program on medical education before a meeting of the American Medical Colleges held in Cleveland, Ohio, in October, 1943. Dr. Rappleye has so effectively summarized the medical education program that we believe his views will be of great interest to our readers and have reprinted below a part of his talk which was published in the

Journal of the Association of American Medical Colleges:

"The problems of maintaining sufficient staffs to carry on the instruction are familiar to all of you. To our question on this point, nineteen of the seventy-two schools report that their staffs are now below the number necessary to provide reasonably satisfactory instruction. Many of the remaining fifty-three schools report that they are at their minimum and any further withdrawals for military duty or by retirement or death will mean inability to maintain their program. A number comment that the staffs are greatly overworked and can not be expected to continue indefinitely at the present tempo.

"In answer to the crucial question of standards of academic performance about one-fourth of the schools report that the standards are not being maintained. It is clear from the replies that the military features of the training programs are not responsible for the deterioration. In fact, a number of deans suggest some improvement in academic effort and student morale as results of the students being in uniform and free from the necessity of many to help support themselves by outside work.

"The drop in performance is ascribed almost entirely to the severe reduction in teaching staffs and secondarily to the accelerated program. Many schools report that about one-third of their most active and able teachers have gone into service. Upon those remaining has fallen the tasks of carrying the instructional load and the care of patients in the wards of the teaching hospitals which on a normal academic year would be a heavy burden. But the accelerated program which requires instruction throughout the calendar year places a demand upon the staffs in the schools which can be met only for a limited time.

"The academic work of the trainees has suffered because of the necessary reduction in instructional guidance and help from the depleted staffs. A number of medical teachers and some of our reports agree that the character of the instruction is changing because of the overworked staffs. Increasingly the teaching in some subjects and in certain schools is becoming of necessity didactic and hurried. The use of the library by trainees is dropping in many places. Students no longer have time for electives, especially in the summer recessed, to do extra work in the laboratories and clinics which were of great value in elevating the quality of professional training not only for the students participating directly but also for those in the regular sections which were usually reduced in number through the elective system. Students do not have sufficient time for reflection and for proper assimilation of the mass of

knowledge encompassed by the medical curriculum which now includes many new items of recent origin or related to the war problems of medicine. Even for the best students the schedule is hard, for the less able the academic achievement is falling in a goodly number of schools.

"The danger signal of a breakdown in scholastic standards is flying. This is disquieting to say the least and augurs badly for even the near future as the fatigue and overwork of staffs increase with consequence further relaxation in their teaching performance. The possibility of a serious situation in medical education shortly must be borne in mind.

"From the data and comments obtained from our inquiry to all medical schools it seems fair to conclude that:

- 1. "Any further depletion of the instructional staffs of the medical schools will result in a serious breakdown of standards of medical training. Already there is definite deterioration in one-fourth of the medical schools.
- 2. "The qualifications and educational preparation of trainees selected and assigned to the medical schools in the future must be kept high if even reasonable standards of academic performance are to be maintained under war conditions.
- 3. "If the present trend continues, consideration may have to be given to a modification of the accelerated program or some assurance for the continuation of adequate instructional staffs in order to maintain the proper instruction of medical officers for the Army and Navy and of physicians for the civilian needs of the future."

The medical profession deserves the grateful recognition and regard of all other callings in modern life. It has always insisted that the practice of medicine is a profession and not a trade.

Trade is occupation for livelihood; profession is occupation for the service of the world. Trade is occupation for joy of the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade makes one the rival of every other trader; profession makes one the cooperator with all his colleagues.—President Faunce, of Brown University, in an address to the Rhode Island Medical Society, 1905.

In view of the favorable results obtained in more than 600 consecutive cases which he reports in The Journal of the American Medical Association for August 7, J. Albert Key, M.D., St. Louis, says that "I believe that the practice of implanting sulfonamide powder in clean operative wounds should become routine in all civilian and military hospitals. This is especially true at this time when, owing to the emergency resulting from the war, so much surgery must be done under abnormal conditions and the incidence of operative infection may be expected to be unusually high."

TUBERCULOSIS CONTROL

SEASONAL MALADIES

In combating the spread of communicable diseases, the isolation of the case throughout the period of marked infectivity is of considerable importance. At best, however, this can be only partially accomplished, for the period of infectivity so often begins hours or days before symptoms sufficiently manifest themselves to make possible a diagnosis. Mild subclinical infections go undiagnosed, yet serve to spread infection to others. Obviously, with such initial gaps in isolation procedure, we can hope to gain but little by being hyper-meticulous in carrying out the latter part of the isolation process. The effort should be two-fold: (a) to prevent, as far as practicable, the spread of infection to others; (b) to keep the time lost by the case in isolation at a minimum.

With this double objective in mind, we should avoid on the one hand, such lax regulations as would permit German measles cases to carry on their regular duties and contacts in the obvious presence of rash and swollen post-cervical lymph nodes, and on the other hand, such strict regulations as would keep scarlet fever patients routinely under isolation for six weeks or more. A well balanced communicable disease control program will endeavor to isolate suspected cases promptly and freely; will release them just as promptly when observation shows the suspicion unfounded; and will extend the isolation only through the definitely and dangerously infective period.

Recommended isolation periods for the more common communicable diseases are as follows*:

Measles. Communicable from the onset of the catarrhal symptoms (usually at least three days before the appearance of the rash) until the catarrhal symptoms have ceased (usually shortly after the return of the temperature to normal and well before the rash has completely disappeared). In a case without complications or abnormal discharges, release from isolation is usually safe any time after the fifth day following the appearance of the rash, provided the catarrhal symptoms have ceased.

Mumps.—Communicable from twenty-four hours preceding the appearance of symptoms until the subsidence of all swelling in salivary glands or involved testicles. Release from isolation is usually safe twenty-four hours after all swellings of salivary glands or

testicles have subsided. (It should be remembered, however, that with adult males the chance of orchitis persists for about one week after the subsidence of the parotitis.)

Rubella (German Measles).—Apparently communicable from twenty-four hours preceding the appearance of the rash until the subsidence of the rash. Release from isolation is usually safe twenty-four hours after the disappearance of the rash.

Scarlet fever. Streptococcic pharyngitis, Streptococcic tonsilitis.—Most communicable in the first two weeks of the illness, communicable in the third week in approximately twenty-five per cent of cases, communicable in the fourth week in approximately five per cent of cases, communicable after the fourth week in approximately one per cent of cases. Release from isolation is usually safe twenty-one days after the onset of the disease, provided there are no complications or discharges. For another three weeks after release from isolation the patient should consider his nose and throat secretions still possibly dangerous to others. Desquamation has no relation to communicability.

Chickenpox.—Infectious from twenty-four hours preceding the appearance of the eruption until there are no longer any actual pustules. Release from isolation is usually safe when all pustules are gone (usually about seven days from onset), and the patient has taken a thorough bath and shampoo. The dry scabs apparently bear no relation to communicability.

Meningococcus meningitis.—Probably communicable throughout the course of the disease and until the meningococci have disappeared from the secretions of the nose and throat. Release from isolation is usually safe when fourteen days have elapsed since the onset and the fever has subsided.

Poliomyelitis.—Apparently communicable the last one or two days of the incubation period, and for the first seven to ten days of the disease (virus may be found in the stools even much later in the disease). Isolation is necessary only during the first fourteen days following onset.

Smallpox.—This disease is apparently the most communicable of all diseases. It is communicable from the inception of the first signs or symptoms until the complete disappearance of all crusts and scabs. There is some evidence that the disease is communicable in the last one or two days of the incubation period. Isolation in screened quarters, free from vermin, is necessary until recovery is complete and all crusts and scabs have disappeared.

Diphtheria.—Communicable from twenty-four hours before the onset of symptoms until the diphtheria bacilli have disappeared from the nose, throat or other site of infection. Isolation should be con-

^{*} Note—These are Navy suggestions. Physicians will know whether or not they conform to local health regulations—Ed.)

tinued until symptoms and discharges have ceased and two successive nose and throat cultures, taken no less than twenty-four hours apart, are negative.—

BuMed News Letter, Bureau of Medicine and Surgery, U. S. Navy, Captain W. W. Hall, Editor. Journal-Lancet, October, 1943.

MEN IN SERVICE

Dr. Howard N. Moses of Salina was kind enough to send us the following interesting news release on the war experiences of one of our Salina doctors of medicine, Lt. Donald A. Anderson and his co-workers. The Bureau of Public Relations of the War Department and the office of Public relations of the United States Navy have given permission for its publication with a few brief deletions:

"Vella La Vella, October 11. On the island of Vella La Vella northernmost of the Solomons group to be wrested from the Japanese, American ingenuity has reached a new high in the 'construction' of a tiny naval hospital, whose facilities rival those of the most modern civilized world institution.

"Materials were scarce but now-famed naval construction battalions 'sea-bees' stepped into the picture and a 30 foot by 40 foot three room hospital—it would be called a 'dispensary' anywhere back home—emerged in the short space of three hectic weeks. Work of the 'sea-bees' is all the more impressive when it is considered their work was performed in between 'condition raids' or raid alerts. The hospital which embraces an eighteen bed emergency ward, sterilization room and operating room is as close to being impervious against even a direct bomb-hit as it has been possible to make it. Hundreds of sand bags have been utilized in its construction.

"Interior of the hospital is an immaculate white. The floor is of native hardwood. Serums, or biologicals are kept in an eight foot kerosene-operated refrigerator in the sterilizing room. But despite the crudities of their surroundings the three doctors on duty here twenty-four hours a day, do just as good work as can be done in any surgical ward anywhere in the United States. Instruments at their disposal leave nothing to be desired, from the surgical point of view. These are lined up in neat rows on shelves which flank the building's walls, or 'bulkheads' as the Navy calls them. Other shelves bear sterilized dressings, gloves, surgeon's outfits, emergency clothing for evacuees, etc.

"Senior medical officer at this naval advance base is Lt. John H. Morton, (MC) USNR 36 of Meadville, Pennsylvania. Assistant medical officers are Lt. Robert G. Price (MC) USNR 34 of Bloomington, Illinois and Lt. Donald A. Anderson (MC) USNR 37 of Salina, Kansas. Drs. Morton and Price handle the surgery, Anderson the medical end of their trade.

"Work these men are doing at this advanced base is probably the most important in the field of war-zone medicine and they are particularly qualified for their jobs. Morton, for example, went to Wisconsin Medical School, interned at Mercy Hospital in Pittsburg, where he specialized in surgery, gynecology and obstetrics and was teaching at the University of Chicago Medical School when he enlisted in December, 1941. Price went to school at Northwestern University, interned at Cook County Hospital in

Chicago, Illinois, and specialized in surgery and general medicine. He came into the Navy in September of 1942. Anderson went to the University of Kansas and interned at St. Luke Hospital in Kansas City, Missouri. He specialized in general work. Anderson was resident at the University of Kansas for a year before enlisting in October, 1942.

"All three of the 'medics' arrived on Vella La Vella last August 15 with the original occupation forces, and as a consequence, are veterans to date of some 154 air attacks. These, however, have failed to dampen their enthusiasm for the work they are doing. In the first three weeks that their hospital has been 'open for business' they have performed some twenty operations and on several occasions, their tiny emergency ward (18 bed capacity) has been filled to over-flowing. Six operations have been performed while air raids were on, all of them dealing with shrapnel victims of bombs dropped only minutes before.

"In the hospital at time of our visit were (and this furnishes an excellent example of the range of work these men are doing) a seaman, just operated on for acute appendicitis, another sailor suffering from a bullet wound; an army boy recovering from a broken knee. This incidentally, was incurred in the transfer ashore of Japanese prisoners rescued from the sea after their destroyer had been sunk in a naval action.

"Nineteen hospital corpsmen aid the doctors in their work under the supervision of Chief Pharmacist's Mate W. P. Johnson, USN 27 of Glenmore, Louisiana, whose seven years in the regular Navy have been spent in working his way up from hospital apprentice to his present position. Two of these corpsmen, M. S. Weller of Elmhurst, Illinois, and W. M. Pearson of Taylor, Texas, are qualified as operating room technicians. Theirs is the job of general supervision of the operating room. Morton speaking: 'The corpsmen have, as usual, done a damned good job.' Although naval hospital facilities are open to all branches of service of American and Allied armed forces, as well as natives and Japanese prisoners of war, the mortality rate here in medical cases has been nil. Surgical deaths among war casualties has been nil, aside from those few patients who have been received in moribund (beyond all hope)

"The mortality rate, or rather complete absence of it, bears eloquent if silent substantiation of the Navy men's belief that they have the most complete medical set up on the island, at least to date.

"Tropical diseases have been the chief medical complaints on Vella La Vella. Sulfaguanidine has been so effective in the treatment of dysentery as to permit return of these patients to their posts within four or five days. Only patients evacuated to rear areas are those cases where a period of prolonged convalescense is indicated, or where elective surgery is required. None of the latter is performed here. Evacuation has been carried out by sea and air, by PT boats, tank lighters, landing craft for infantry and DC-3's. Only the most serious surgical cases are kept in the hospital at night, when enemy float planes are invariably overhead. Run of the mill medical cases are transferred to family-type fox-holes, carved into the coral like surface to a depth of approximately ten feet. These latter patients are, in the day-time, nursed in two tent encased wards adjoining the hospital. Also in the immediate area are tents housing laboratory, pharmacy and supplies. A fourth tent is provided for six hour a day sick call."

Lt. Col. Earl B. Ross of Wichita was the writer of a letter in the Sedgwick County Bulletin which we think is well worth reprinting for our readers: "Saw Anderson (Lt. H. O. Anderson, now a captain also from Wichita) just before and after arrival in African theater, but was separated from him. Although I have not seen him for months, his letter (in a former Bulletin) gives a very good idea of location during the period of Sicilian operations.

"A few words about my own hospital. You will pardon the statement of ownership. We were very active in Sicily, part of us having been in on the original landing effort. We handled a considerable number of men during the campaign. Was much surprised at the low death rate experienced. This is strictly a field unit, and consider people in houses as not quite in our class. Note that Ernie Pyle stated our hospital in Africa did all the work. Can't tell you the number of patients this outfit handled, how many operations were done, or how often we moved. Can assure you the figures were pretty big and there were other field units quite as active as we. Incidentally, our customers had little to say about how easy the Sicilian Campaign was.

"Now we are in Italy. If luck runs in threes, we are not too anxious to tackle another amphibious operation. What we need now, especially, would be webbed feet. Plenty of rain and excellent mud. Our location was once a nice hay field. In spite of rock we hauled in to make roads, the place has the appearance of a mud hole, at least in spots. There are many interesting things about this area, but the censor doesn't think anyone else should know about them now.

"Note the appeal for nurses. One statement caught my eye. 'Nursing with armed forces is not filled with bombings, front line duty, extreme suffering and fear.' Well, our nurses would not trade their places with anybody. They take the inconveniences, mud, and everything else in their stride. Their opportunity to serve these men, who really have been through tough times, is all they ask. Strange to say, assignment to field-type units seems much in demand. Hope the Kansas girls step up and refuse to let anyone else have their part."

Dr. Raymond C. Clapp of Wichita has been promoted to a captain.

A letter from Lt. Austin J. Adams of Wichita recently published in brief says: "Things have been happening to me in rapid succession. We are not under Admiral Halsey, as are all the marines in this area. You have been reading of my battalion activities. The news reports we get concerning ourselves are seemingly not very important, yet we all feel we are doing a good job.—This is really a beautiful place. The climate is surprisingly cool, and, although one is comfortable in shorts and shoes in the daytime, the night requires clothing, for insect protection, as well as from the cool dampness of the jungle. I have three pairs of pants now, all green dungaree. Two I cut off short for day use, and one long, for night, to protect against mosquitoes—put them in our socks, also button the collars on our shirts.

"Our supply of food and necessities—candy, gum, shaving needs, and fruit juices—seems to be unlimited. Today someone got hold of a can of chicken. I made biscuits and creamed the chicken, just like mother used

to make. Thanksgiving our turkey got through, along with cranberries and pumpkins.—We continue being busy, although with things now more of a general practice nature."

Capt. Charles T. Sills of Newton, located at Fort Bliss, Texas (recently presented a paper on "The Heart in Acute Infectious Mononucleosis" before the El Paso County Medical Society.

The Great Bend Herald has the following to say: "A corporal of Ellinwood was agreeably surprised recently in Italy where he is with Uncle Sam's continental invaders, to have his family physician, Dr. R. J. Leiker, now a captain in the medical corps, to attend him for an attack of rheumatism." Capt. Leiker formerly lived in Great Bend.

Capt. Clyde B. Trees of Topeka, now stationed at Asheville, North Carolina, has been informed of his acceptance by the American Board of Orthopaedic Surgery following a recent examination.

Capt. Spencer Boyd of Topeka stationed at Romulus, Michigan, was recently home on a furlough.

The War Department announced the promotion of Roy C. Knappenberger of Penalosa to major.

"When a WAC is sick abed 2,000 miles from home and her mother, the next best thing is to have a doctor from the home town looking after her," says the Larned Tiller and Toiler in a recent news story on Pvt. Betty Cone, Larned WAC with the Army Air forces and Capt. Joe G. Reed, flight surgeon and a former Larned physician. Both Captain Reed and Private Cone are stationed at Geiger Field, Washington.

Capt. W. Spencer Fast of Atchison has been transferred from Camp Carson, Colorado, to an address with an APO out of San Francisco, California.

Lt. Donald E. Bux of Columbus is now stationed in New Zealand with the Army Medical Corps according to news releases from the Columbus Advocate. Dr. Bux writes to friends that their chief diversions are insects and skin infections.

Dr. Richard Kiene knows how important blood plasma is on the battlefield as he has recently returned from six months in the Solomon Islands. He was in Topeka to help supervise the Red Cross blood bank. The Topeka paper has the following to say: "The Navy doctor landed with the Marines in the Solomons and saw blood plasma used—he administered it to the wounded himself. He contracted malaria fever, was returned to the states and is still under treatment. Dr. Kiene, who before the war was an orthopedic surgeon, is a native of Concordia."

 several months and certainly miss it. You might be interested to know I have recently received my captaincy. Herbert L. Songer, Capt. (M.C.)" We are indeed sorry but we had lost track of you and Journals mailed to your old address had been returned to the office. Dr. Songer had formerly lived in Lincoln.

Captain Joseph W. Manley of Kansas City has been transferred from Camp Rucker, Alabama, to Camp Butner, North Carolina.

Major Don C. Wakeman of Topeka and formerly on the editorial board of the Journal has been transferred from Fort Riley to Ft. Leonard Wood, Missouri.

Capt. Carleton H. Lee of Pleasanton was seriously wounded in action in the Mediterranean area on November 26, according to war department information. Although no definite information has been received by Mrs. Lee in regard to the nature of his wounds, it is known that he was detained in the hospital for some extended time. Capt. Lee entered service in October and was stationed in North Africa.

Announcement from the Army air base at Herington was made of the promotion from captain to major of Dr. Darrell L. Evans of Manhattan. Major Evans was stationed at the Army air base at Lincoln before being transferred to Herington.

Capt. G. O. Giffin, a former Arkansas City physician, who was seriously wounded in Tunisia in a land mine explosion, expects to be transferred from White Sulphur Springs, Virginia, to Fitzsimmons General Hospital in Denver, Colorado. In a letter received by a friend he wrote that he probably would be confined to bed for another year and would undergo operations for bone and skin grafting. Capt. Giffin, who was a former member of the Society moved from Arkansas City to Littleton, Colorado, in 1941, but will be remembered by many members.

Capt. L. L. Cooper of Fort Scott has been transferred from San Antonio, Texas, to Sheldon, Missouri.

Major Alfred H. Hinshaw of Kansas City has been transferred from Camp Ellis, Illinois, to the 340 Station Hospital at Atlantic City, New Jersey.

Lowest death rate in the history of the United States death registration states was recorded in 1941, according to the United States Census Bureau. Provisional mortality statistics for that year, just tabulated, show a crude death rate of 10.5 per 1,000 population. The 1940 rate was 10.8, a slight increase over the previous low level of 10.6 reached in 1938 and 1939. There were 21,362 fewer deaths in 1941 than in 1940. Most of the decrease occurred in the rural areas. The greatest decreases were in the District of Columbia, Idaho and Vermont. The greatest increases in death rates for individual states were in Arizona and Virginia. The total number of deaths for the entire nation for 1941 was 1,395,507.—Science.

NEWS NOTES

STATE MEETING PLANS

The plans for the 85th annual meeting of the Society are getting underway. The Municipal Auditorium, between Seventh and Eighth on Quincy in Topeka has been reserved and the commercial and scientific exhibits as well as the speakers meetings will be held there.

The committee in charge of the tehnical exhibits forwarded the description of the floor plans and other data on booths to the prospective list of chemical ,pharmaceutical and technical companies in January and has already received a considerable number of reservations for booth space at the meeting.

Dr. Dwight Lawson, chairman of the program committee assures us a splendid group of speakers has been selected for the meeting, but is not ready to release their names to us at this time. We believe there will be several meetings to discuss war subjects.

Mark those two dates in May, the 10th and 11th, on your calendar so that you will plan to attend both days of the annual meeting this year.

MEDICAL PRACTICE VIOLATOR

The District Court of Dickinson County recently enjoined Laurence Moore, Herington osteopath, from the practice of medicine and surgery in Kansas.

The order was handed down on January 3 and signed by Judge Jas. P. Coleman of the District Court of Dickinson County and reads as follows:

"It is therefore by the Court considered, ordered, adjudged and decreed that the defendant, Laurence A. Moore, be, and he is hereby, ousted and permanently enjoined from the practice of medicine and surgery in violation of the laws of the state of Kansas."

The case was brought against Moore on the relation of the county attorney of Dickinson County and the Board of Medical Registration and Examination of the state of Kansas, by Mr. H. Lloyd Ericsson of Emporia, its attorney.

SELECTIVE SERVICE RULINGS CHANGED

The new rulings for change in the screening examinations for selectees will greatly affect the amount of work done by the many examining physicians throughout the country.

According to Lt. Col. Seth A. Hammel, state medical officer of the Kansas State Selective Service System, with headquarters in Topeka, "The Selective Service greatly appreciates the wonderful work the doctors in Kansas have done on these examining and specialty boards. We believe that the new ruling will cut the work of the doctors on the Selective Service boards about eighty per cent."

The 126 selective service boards and the seventeen advisory medical boards in Kansas will still continue to function and their work will continue indefinitely but becaus of the new rulings the amount of examining by the local boards will be greatly reduced.

The clerk of the local Selective Service Board will now act on the preliminary screening test, except where the registrant claims to have a manifestly disqualifying defect, in the case of 4 F's, the doctor not the clerk must act on all rejections. All 4 F's in the state have recently been reviewed by the various selective service boards.

Serological etss by the examining physician of the local boards have been eliminated except in very special cases and two changes have been made in the qualifications as to teeth and in regard to hernias. All hernias are disqualifying except an inguinal hernia which does not descend into the scrotum.

Lt. Col. Hammel says: "About ten per cent are eliminated locally and twenty-seven of the ninety per cent of the registrants are eliminated at the induction stations. Up to September 15 approximately seventy per cent of the men examined by the board and the induction stations were inducted for general service, seven per cent were inducted for limited service and approximately twenty-five per cent were rejected."

The inductee, when he receives his papers from the local board, reports to Leavenworth with three copies of his physical examination papers. The new screening orders were effective February 1, 1944.

APPOINTMENT

Dr. F. C. Beelman, Secretary of the Kansas State Board of Health, announced the appointment of Mr. Reginald D. Glandon of Kansas City as the new attorney member of the Board.

Mr. Glandon takes the place recently vacated by Mr. William E. Scott, also of Kansas City, who resigned to enter the military service.

Other members of the board are as follows: Dr. George I. Thacher the president, of Waterville; Dr. H. L. Aldrich of Caney; Dr. J. F. Gsell of Wichita; Dr. Hugh A. Hope of Hunter; Dr. J. L. Lattimore of Topeka; Dr. G. A. Leslie of McDonald; Dr. F. L. Loveland of Topeka; Dr. R. T. Nichols of Hiawatha and Dr. Clyde D. Blake of Hays.

SCIENTIFIC EXHIBITS

The committee on scientific exhibits of the 85th annual meeting, which will be held in Topeka on May 10 and 11, 1944, is most anxious that Kansas physicians participate in the scientific exhibit sections this year.

The war will no doubt limit the number of exhibits shown and many of our Kansas physicians who have had fine exhibits on display at past meetings are now in the armed forces. In past years it has been the custom of society committees to prepare exhibits and we believe some of the committees are again making plans along this line.

If you are interested in space for an exhibit at this year's meeting please write to the chairman of the committee on scientific exhibits—Dr. W. J. Walker, Santa Fe Hospital, Topeka, Kansas, for information.

LT. COL. WILLIAM C. MENNINGER APPOINTED CHIEF

The War Department recently announced the appointment of Lt. Col. William C. Menninger of the Menninger Clinic and Sanitarium of Topeka, as chief of the neuropsychiatric branch in the office of the Surgeon General. The appointment of Lt. Col. Menninger will fill the vacancy created by the death of Col. Roy D. Halloran, the former chief.

Dr. Menninger is a member of the Kansas Medical Society, the author of the series of psychiatric articles recently published in the Journal, and former neuropsychiatric consultant for the Fourth Service Command.

The Army's neuropsychiatric service has been created to screen out at induction centers men whose mental instability will render them unsuitable for combat or other military duty, and to rehabilitate men suffering from nervous disorders incurred in military service.

X-RAY TECHNICIANS MEETING

The annual meeting of the Kansas Society for X-Ray Technicians will be held on March 25 at the Hotel Jayhawk in Topeka. According to Sophia McQuillen, R.T. of Clay Center, president of the Kansas organization, it is hoped that many physicians will bring the meeting to the attention of their technicians and to technicians in the hospitals in the state in order that the meeting will be well atended. A cordial invitaion is extended to all x-ray technicians in Kansas.

The following program has been scheduled: 8:00-9:00 a.m. Regisration and Call to Order—Sophia McQuillen, R.T. president, Clay Center.

Address of Welcome—Mayor Frank J. Warren, Topeka. "Salpingography"—Barrett A. Nelson, M.D., Manhattan. "Mastoid Radiography, Two View Technique"—Sister

M. Francis Salesia, R.T., Emporia.

"Interesting Phases of Military Radiology"—Raphael Pomeranz, Major, Chief of the X-Ray service of Winter General Hospital, Topeka.

Business Meeting.

12:30 Luncheon—J. L. Lattimore, M.D., president of the Kansas Medical Society, Topeka, as guest speaker.

2:00 p.m.—Afternoon session

"Darkroom Technique"—Martha Jane Hay, R.T., Sterling.

"Double Stereos"—Arthur K. Owen, M.D., Topeka.

"Various Uses of X-Ray"—Anna M. Johnson, R.T., Wichita.

Selected Subjects—Representative of General Electric X-Ray Corporation.

Spot Radiography—Neola Kanauver, R.T., Wichita. Selected Subject—H. L. Hiebert, M.D., Topeka. Business Meeting.

7:00 p.m.—Dinner and program.

SNYDER MEMORIAL FOUNDATION

A charter was obtained on November 8, 1943, for the establishment of a medical and surgical research foundation in honor of the late Dr. Howard L. Snyder of Winfield who died on August 16, 1940.

Dr. Snyder was the president of the Kansas Medical Society in 1936 and 1937, a member of the board of governors of the American College of Surgeons, a representative and active member of the American Society for Control of Cancer, a delegate of the American Medical Association from Kansas, and a member of the Kansas State Board of Regents.

The new organization is a non-profit sharing one, sponsored by Mr. A. W. Kincade of Wichita; Major Howard E. Snyder, now in the armed forces, and Dr. Cecil D. Snyder of Winfield, sons of Dr. Snyder and Dr. Howard Jones of Winfield. The article of incorporation state that

the foundation is authorized to act in the "investigation of and the research concerning the problems of medicine and surgery, and the dissemination of knowledge thus acquired."

H. R. 786

The Bureau of Legal Medicine and Legislation of the American Medical Association has recently advised the central office that the Tolan chiropractic bill (H.R. 786) is on hearing before the sub-committee on the judiciary House of Representatives of the seventy-eight Congress.

The bill if enacted will amend section 40 of the United States Employees' Compensation Act to include chiropractic practitioners, giving them the right to treat the beneficiaries of the act.

Oral testimony submitted on behalf of medicine and against the measure was submitted by various state medical societies in the form of letters, and in person by the Hon. A. L. Miller, M.D., a Representative in Congress from Nebraska; Dr. Barney J. Hein of Toledo, Ohio, and Dr. W. C. Davidson, dean of Duke Medical School of Durham, North Carolina.

Dr. Hein made the following remark as a part of his statement at the hearing:

"In 1939, it may be of interest to the committee to know, an initiation measure promoted by the chiropractors, proposing to grant to them the right to treat workmen's compensation cases, was overwhelmingly defeated in the state of California, the home, incidentally, of Representative Tolan who has sponsored for several Congresses the chiropractors' bill for this Federal recognition. During the same year, 1934, a similar initiative measure was voted down emphatically by the electorate of Oregon."

Additional progress on this and other congressional measures effecting the profession will be published from time to time.

CONGRESS ON MEDICAL EDUCATION AND LICENSURE

The fortieth annual congress on Medical Education and Licensure was held in Chicago on February 14 and 15, 1944. The congress this year was under the auspices of the Council on Medical Education and Hospitals.

The following problems of interest to those attending were discussed: the medical school program in wartime, hospital training of medical graduates, readjustments of returning medical officers, financing higher education, distribution of medical care, medicine in the Navy, the expanding field of public health, medical manpower for civilians, wartime graduates training, licensure trends and medicine, premedical training, basic and clinical medical sciences, hospital internship, medical licensure aspects, the amended Nebraska Medical Practice Act, and medical legislation.

WAIVERS FOR LIMITED ARMY MEDICAL SERVICE

The following opinion was recently released by the office of Procurement and Assignment Service of the War Manpower Commission of Washington, D. C., in regard to waivers for known physical defects which a physician signs upon being appointed for limited service in the Army Medical Corps.

Clarification of this recurrent question was made by the office of the Judge Advocate General of the Army as follows:

"Response is made to our oral inquiry whether acknowledgment, on the accompanying form, of existing physical defects would preclude a person from thereafter claiming benefits to which he would otherwise be entitled on account of the service connected aggravation of such defects. As to the defects acknowledged, the execution of such an instrument merely provides additional evidence of their existence, and to that extent would operate to preclude the person involved from thereafter claiming benefits on account of them. It is the opinion of this office, however, that the mentioned form does not purport to be a waiver of possible future benefits to which the individual might become entitled by reason of any service-connected aggravation of such defects, and would not operate to deprive the individual of any possible benefits on account of such aggravation.'

THE UNIONIZATION OF MEDICINE?

The following is a trend of thought developing in some states that will have to be developed if the Wagner-Murray-Dingell bill is enacted:

"At the Annual Session of the Colorado State Medical Society, which was held in Denver September 29 and 30, Dr. Ralph S. Johnson, of La Junta, the retiring president, offered the following resolution:

"Be it hereby resolved that this House of Delegates of the Colorado State Medical Society go on record as favoring the formation of a Union of members of the American Medical Association and instruct our delegates from Colorado to present such a resolution to the next meeting of the American Medical Association."

Dr. Johnson said: "Such an organization should plainly state in the preamble to its constitution that the purpose is to give political and economic protection to all members and to develop a bargaining body.

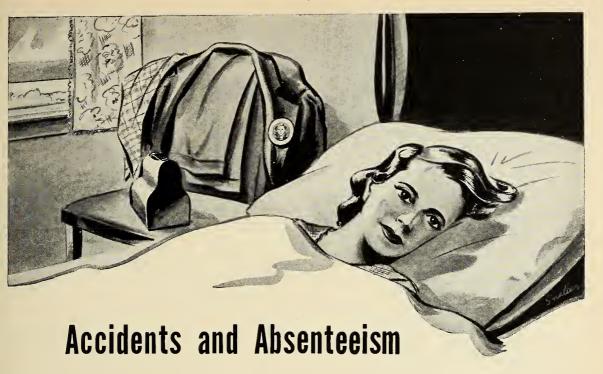
"It is immaterial whether this organization is separate from the scientific body, as the National Physicians Committee is at present, but we should have some definite economic and political administration which is approved by, elected by, and responsible to the membership.

"This term union was coined many years ago for artisans, but as time passed, these groups have become political and economic forces, and in this democracy of ours have become mass voters with special privileges.

"Thirty years ago medical men were individuals with no political and few social responsibilities. Now we have definite groups in army service, mass relief and public health. We have solved the army service without coercion through our Procurement and Assignment Committees.

"In a similar way, we must meet the demands for public health and mass relief if we are to be independent and successful. This will require a more aggressive program than a scientific society can assume without a threat of excessive taxes. At present we are not allowed to spend our funds to influence legislation.

"The American Medical Association spent more than \$100,000 last year trying to defend a vague system of ethics and an old nomenclature. I have no criticism of the court procedure, but I feel that it is time to change our nomenclature, become a union, and regain our constitutional rights. As a union, we may become the bargaining body with the U. S. government agencies, and as such, we hold the key to every social relief plan. This is the answer



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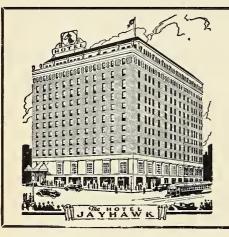
to the Wagner-Murray-Dingell bill. They may rewrite this bill many times, but our services will be included.

"We cannot expect 114,000 to hold rigidly together and this arrangement should not be a closed shop. The minority will protect the majority actions. This plan should be open. There are stigmata attached to an effort to protect a group which is so essential and which has been as unselfish and patriotic as the American Medical Association."

SHORT COURSE IN MEDICAL PROTOZOOLOGY

A short course on Medical Protozoology, the second and a repetition of the course offered in October, 1943, will again be held on February 28 to March 4 at the University of Kansas Department of Zoology at Lawrence. Because the available laboratory facilities will only handle twenty-five enrollees and the October course was in such demand it was decided by the University Extension Division at Lawrence that this second course would be held again between semesters. Technicians taking the previous course have requested that a course on "Helminthology" be held in the near future.

The program for the short course includes the following work: preliminary work in Malaria, lectures and laboratory; Trypanosoma and Leishmania (the sleeping sickness of Africa and South America); Endamoeba histolytica; Amebae; Intestinal flagellates of man; and intestinal ciliates and



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sporozoa. Enrollment is made through the University of Kansas Extension Division and a fee of \$15.00 is charged to cover the cost of the course.

All lectures and laboratory periods will be conducted by Miss Mary E. Larson, assistant professor of zoology of the University of Kansas. Physicians who desire that their technicians attend the school should make registrations at once.

MEMBERS

Dr. A. H. Biermann of Garden Plain is the co-author of an article entitled "A Case of Poliomyelitis in a New-born Infant" published in the January 29 issue of the Journal of the American Medical Association.

Abstracts of articles by three Kansas members were to be found in the 1942 Year Books. Dr. Mahlon Delp of Kansas City, now a lieutenant colonel in the Army was the author of the article "Absorbic Acid in the Treatment of Arsenical Dermatitis" originally published in the December, 1941, Journal and abstracted in the Year Book of General Therapeutics for 1942; "Management of Edema and Nephritis in Children" by Dr. James H. Bena of Pittsburg, now a major in the Army, which was first published in the September issue of the Journal and abstracted in the Year Book of Pediatrics for 1942; and "Benign Tumors of the Mesentery" by Dr. W. M. Mills of Topeka, first published in the March, 1942, issue of the Journal and abstracted in the Year Book of General Surgery for 1942. Several other abstracts from the Journal were published but these were articles written by out of state authors.

Dr. M. J. Miller of Plainville has moved to Kansas City.

Dr. R. H. Munford of Belleville has moved to La Habra, California.

The article by Dr. J. B. Nanninga of Newton published in the October, 1943, issue of the Journal entitled "Bacillary Dysentery" was abstracted in the November, 1943, issue of Southern Medicine and Surgery.

Dr. Mayer Shoyer, formerly of Soldier and more recently of Holton, has returned to Soldier where he will open an office. Dr. Charles E. Vestle of Humboldt is in Chicago where he is doing post graduate work at the Cook County Hospital.

DEATH NOTICES

Dr. Fred M. Anderson, 65 years of age of Nickerson, died at a Hutchinson hospital on January 17, 1944. He was graduated from the St. Louis University School of Medicine in 1904. He was a former member of the Reno County Medical Society.

Dr. Henry H. Asher, 33 years of age of Manistique, Michigan, formerly director of public health of Sedgwick County and later a director of the Kansas State Board of

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Health of Topeka, died of pneumonia on January 13, 1944. He was graduated from the University of Kansas School of Medicine in 1934 and was a member of the Kansas Medical Society.

Dr. Frank A. Cavanaugh, 83 years of age, died on January 18 at his home in South Haven. He was graduated from the Eclectic Medical College of Cincinnati, Ohio, in 1904 and was an honorory member of the Sumner County Medical Society.

Dr. James A. Pinkston, 82 years of age, died on January 25 at his home in Independence. He was born in Gallatin County, Kentucky, on July 10, 1861, and was graduated from the Medico-Chirurgical College of Kansas City in 1902. He was an honorary member of the Montgomery County Medical Society.

Dr. Matthew Thompson Dingess, 76 years of age, died on January 8 at his home in Atchison. He was born on November 6, 1867, in Hamlin, West, Virginia, and was graduated from the Kentucky School of Medicine in Louisville in 1890. He was a member of the Atchison County Medical Society.

Dr. Luther Wendall Fowler, 67 years of age, died on October 18 of carcinoma of the lung at his home in El Dorado. He was graduated from the American Medical College of St. Louis in 1899 and was a member of the Butler-Greenwood County Medical Society.

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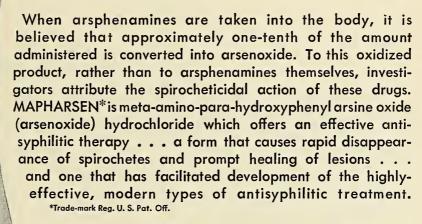
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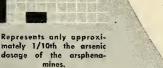
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COUNTY SOCIETIES

The regular meeting of the Clay County Medical Society was held in Clay Center on January 20. The past year instead of importing speakers for the meetings it was decided to select one local doctor to discuss the main topic for the meeting followed by a general discussion of the members. The following topics were discussed during the year: influenzal infection, hypertension and complications, primary and secondary anemias, coronary diseases and associated pathology, appendicitis, pathology of the eye as encountered in general practice, sulfonamides, and the business of the Society. Three members of the organization are in service: Dr. McIlvain is still stationed in the Aleutian Islands, Dr. McVey is at a point of embarkation for oversea duty and Dr. Severt Anderson in active duty somewhere in the Pacific aboard a destroyer.

The annual banquet of the Cowley County Medical Society was held at the Winfifield Country Club on January 28. The wives of the members and the medical officers at Strother Field and their wives were guests at the banquet. Judge W. F. Lilleston of Wichita spoke on "Private Lives of the Dictators" and presented a thumb-nail biograp' y of certain European dictators.

The Ford County Medical Society held a meeting on December 9 at Dodge City. Dr. Frank L. Feierabend of Kansas City, Missouri, reported on a case report of "Acute Osteomyelitis in a Nine Year Old Child Treated With Penicillin and No Surgery."

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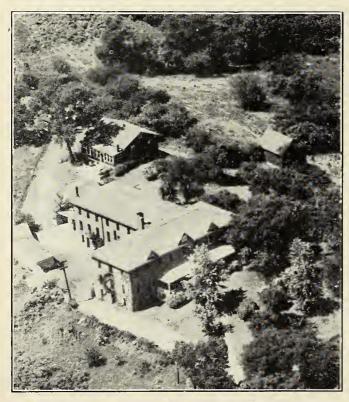
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^{*}Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245. **Laryngoscope, 1935, XLV, No. 2, 149-154.

The members of the Franklin County Medical Society, at a meeting held on January 5 at Ottawa, elected the following officers: Dr. J. R. Henning of Ottawa as president; Dr. J. R. Smithheisler of Richmond as vice-president and Dr. P. R. Young of Ottawa as secretary-treasurer.

The new officers elected by the members of the Labette County Medical Society at their meeting held in Parsons in January are as follows: Dr. I. J. Waxse of Oswego, president; Dr. N. C. Morrow of Parsons, vice-president; Dr. O. E. Stevenson of Parsons, secretary-treasurer and Dr. R. W. Urie of Parsons as censor. The next meeting will be held on February 23.

The Miami County Medical Society announced that the following new officers had been elected at a recent meetingt Dr. Paul A. Petitt of Paola, president; Dr. W. L. Speer of Osawatomie, vice-president; Dr. Joseph Fowler, Osawatomie, secretary-treasurer and Dr. J. W. Kelly of Louisburg as the delegate to the state meeting.

The Marshall County Medical Society held a meeting in Marysville on February 3. Dr. O. G. Hutchinson of Marysville was elected president and Dr. H. H. Haerle of Marysville was elected secretary-treasurer of the organization.

The Riley County Medical Society held its election of officers at a meeting in Manhattan. Dr. M. O. Steffen was elected president; Dr. W. H. Clarkson, vice-president and Dr. W. C. Wood, secretary-treasurer. All officers are from Manhattan.

The Washington County Medical Society held a meeting in Washington on January 11.

Ants that get into the sugar bowl or other food, usually considered a harmless pest of tropical regions, are now incriminated as villains that probably spread dysentery, one of the disease scourages of the tropics which are a special danger to Armies fighting in tropical regions.

Experiments in which ants actually did carry dysentery germs on their feet, leaving a twenty-four-hour trail of the germs wherever they walked, are reported by Dr. Sophie Deller Griffitts, of the School of Tropical Medicine at San Juan, Puerto Rico.—Science News Letter.

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BOOK NOOK

BOOKS RECEIVED

THE THERAPY OF THE NEUROSES AND PSY-CHOSES, A Socio-Psycho-Biologic Analysis and Resynthesis—Samuel Henry Kraines, M.D., Associate in Psychiatry, University of Illinois, College of Medicine; Assistant State Alienist, State of Illinois; Diplomate of American Board of Psychiatry and Neurology. Published by Lea and Febiger of Washington Square, Philadelphia, Pennsylvania. Priced at \$5.50.

The author has written this book to aid the physician, who has not specialized or made a study of psychiatry, in his dealing with psychoneurotic patients. The cases cited are from the authors own experience and deal with the type most frequently found in the doctors office. He describes the procedure used in treating each type. The book is practical and will be of value in the physicians library.

PENICILLIN, Annotated Bibliography — Published by the Library of the Winthrop Chemical Company, Inc., 170 Varick Street, New York, 13, N. Y. A booklet of eightyone abstracts of the recent literature on the subject which is now under a great deal of discussion. Copies may be secured by writing to the Library of the Winthrop Chemical Company.

The annual reprint of the reports of the Council on Pharmacy and Chemistry of the American Medical Association entitled New and Non-official Remedies, 1943, has been received in the office. The Neurological Hospital, 2625 The Paseo, Kansas City, Missouri. Operated by the Robinson Clinic, for the care and treatment of nervous and mental patients and associated conditions.



The Library of the Medical Department of the University of Kansas has every dee sire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and textbooks.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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ANNOUNCEMENT

To extend to the physicians in the armed services the best facilities of American medicine in the interest of our fighting men, a series of Wartime Graduate Medical Meetings is in the process of organization under the auspices of the American Medical Association, the American College of Physicians and the American College of Surgeons, The Journal of the American Medical Association announces in its May 1 issue.

These meetings are authorized, as far as they concern the armed forces, by the Surgeon Generals of the Army, Navy and Public Health Service. The organizations concerned have appointed a committee of three men—one from each organization—to proceed with the work of administration.

It is proposed to hold the meetings in service hospitals. Qualified authorities have been appointed as national consultants in the various special fields of medicine.

MEDICAL ASSISTANTS SOCIETIES

The regular meeting of the Sedgwick County Medical Assistants Society was held in Wichita on January 19. Forty-two members and guests were present. Mrs. Corrine Wilson of the Business Preparatory School was the guest speaker. The following new officers conducted the business meeting: Zura Crockett, president; Helen Hall, vice-president; Martha Heitz, secretary and Opal Kaminke, treasurer.

The Reno County Medical Assistants Society met on February 8 in Hutchinson at the Wiley Tea Room for dinner. The organization has been conducting a word study and Ruth McGaughey had charge of the study for that night. Mrs. Carolyn Givens gave a paper on "Blood Plasma"

NOTICE OF DUES

The 1944 state Medical Assistants Society membership dues do not seem to be coming in so very fast according to Mrs. Faye Bullard, secretary of the state organization. All state dues were due January 1, 1944 and must be paid before the state meeting in May in order that your membership card may be presented at the registration desk for admittance to the meetings. Please send dues to Miss Irene Miller, Gazette Building, Emporia, Kansas.



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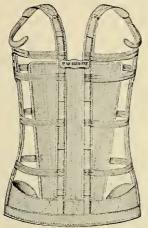
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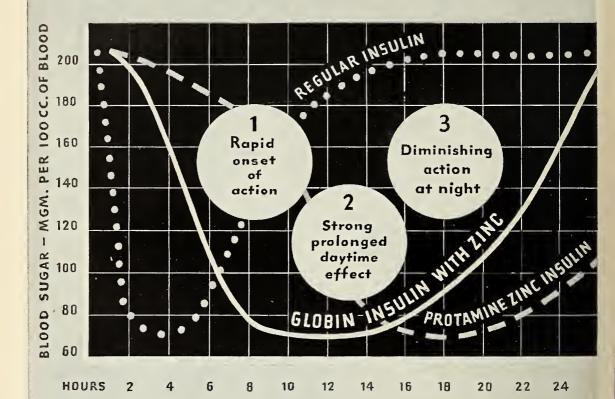
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AUXILIARY

PRESIDENT'S MESSAGE

It is very important that the auxiliaries meet regularly even if now the groups consist of only a few women. Little will be accomplished as individuals; we gain inspiration by meeting and planning together. It is difficult to carry out the National program when the county meetings are only held two or three times a year. Many times the members get the information too late to participate in the plan.

It is again necessary that we stress legislation. Study groups should be formed if they have not already been organized and each auxiliary member should know how to present the facts about the Wagner-Murry-Dingell bill. We do not want the private practice of medicine lost while so many of our doctors are away and cannot protect their interests. Each wife left at home should be doubly active in helping to defeat this bill.

It will not be long until you will be sending in your yearly reports. Be sure to keep a record of everything you have done so this report will be complete. If you have been a little slow in your work maybe you still have time to accomplish something these last few months.

The ninth of February I visited the Wilson County Auxiliary, being the house guest of Mrs. E. D. Duncan, the county president. Their group is small, but all are taking an active part in carrying through their auxiliary program.

Sincerely,

Mrs. E. E. Tippin

AUXILIARY NEWS

The Women's Auxiliary to the Shawnee County Medical Society were entertained with a desert luncheon on February 14 at the home of Mrs. W. C. Menninger in Topeka. Mrs. Vernon C. Wikston and Mrs. R. E. Pfuetze were the assisting hostesses. Dr. David T. MacFarlane, chairman of the state board of social welfare was the guest speaker. The Shawnee county organization is spending the first and fifth Mondays in the surgical dressing division of the Red Cross and has had an especially good representation of membership in attendance.

The Women's Auxiliary of the Wyandotte County Medical Society held its annual Public Relations tea at Bethany Hospial Nurse's Home in Kansas City on February 11. All of the officers of the various women's clubs in the city and the Parent Teachers organizations were guests of the group. Mr. Oliver Ebel, executive secretary of the Sedgwick County Medical Society was the guest speaker. Dr. Lewis G. Allen conducted a question and answer forum at the close of the meeting. Mrs. Harry Butler sang a number of selections accompanied by Mrs. Holly Carter. Those in charge of the meeting were: Mrs. J. E. Barker, Mrs. L. B. Gloyne, Mrs. E. R. Millis, Mrs. P. M. Krall, and Mrs. C. E. Hassig. Hostesses for the meeting were: Mrs. F.S. Carey, Mrs. I. F. Fulton, Mrs. Galen Tice, Mrs. Clarence Weber, Mrs. Max Allen, Mrs. John Bowser, Mrs. L. A. Calkins, Mrs. Emery King, Mrs. Paul Lorhan, Mrs. R. L. Lee, Mrs. C. A. Gripkey, Mrs. E. G. Neighbor, Mrs. L. B. Spake, Mrs. A. T. Steggman, Mrs. W. W. Summerville, Mr. T. R. Hamilton, Mrs. T. J. O'Connell, Mrs. Merle Parrish, Mrs. E. A. Reeves, Jr., and Mrs. Bernard Goldblatt.

The Wynadotte County Medical Society entertained their wives and the wives of the men in service at their annual banquet held at the Hotel Muehlebach recently. The entertainment and decoration committee for the banquet from the Auxiliary included the following: Mrs. John A. Billingsley, Mrs. Francis Carey, Mrs. Donald Medearis, Mrs. L. B. Gloyne and Mrs. E. R. Millis. Capt. Irwin S. Brown gave a resume of his experiences in the service. Captain Brown has served in New Zealand, New Caledonia and Australia. He is now in charge of the out patient clinic department of the Navy in Kansas City.

The Women's Auxiliary to the Sedgwick County Medical Society held a luncheon on January 10 at Droll's English Grill in Wichita. A business meeting followed the luncheon and reports on war participation activities and Hygeia.

The Women's Auxiliary to the Marshall County Medical Society held a meeting in Marysville on February 3 and elected the following to office: Mrs. W. R. Breeding of Marysville as president; Mrs. M. A. Brawley of Frankfort as vice-president; Mrs. R. L. McAllister of Marysville as secretary and Mrs. C. M. Newman of Axtell as treasurer.

STATE MEETING PLANS

Mrs. J. L. Lattimore of Topeka, general chairman of the committee for the state meeting of the Women's Auxiliary to the Kansas Medical Society, called a meeting of her committee recently to discuss the plans for the meeting which will be held in Topeka on May 10 and 11, 1944. Plans for the meeting will be announced in the next issue of the Journal.

THE UNITED STATES CADET NURSE CORPS PROGRAM

"In what way can the Woman's Auxiliary be of service to the United States Cadet Nurse Corps? There are at least four ways in which you, both as individuals and as members of an organization, can be of great help:

- 1. By recruiting additional student nurses.
- 2. By helping interested girls choose the right school.
- 3. By holding and strengthening the interest of candidates for the Corps between the time they seek information and the time they are admitted.
- 4. By assisting local nursing councils and local hospitals in staffing hospital Information Centers for the Corps.
- ". . . Make sure that a poster and material on the United States Cadet Nurse Corps are in your husband's office. You can, in addition, see that posters and publicity material are placed in prominent location in your community.
- ". . . If you need further information, the National Nursing Council for War Service, 1790 Broadway, New York, New York, will be glad to help you. Also available is a new pamphlet, 'How to Choose a School of Nursing,' recently issued by the Division of Nurse Education.'—Lucille Petry, R.N., Director Division of Nurse Education, United States Public Health Service, in the December, 1943, issue of The Bulletin.

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RENAL CALCULI-VISCERO UROLOGIC COMPLEX*

O. W. Davidson, M.D.

Kansas City, Kansas

Renal calculi may assume rather large proportions before detection. They may present few or no symptoms commonly expected of such pathology.

Since an honest confession is good for anyone I wish to present early in this series salient features



F.41.PAIN ACROSS BACK
PAIN MOSTLY ON LEFT.
FREQUENT URINATION.
MANY PUS CELLS IN URINE.
LT. URETER CATHETERIZED.
SULFA DRUGS RELIEVED
ALL SYMPTOMS.
ONE YEAR LATER..X-RAY
LARGE RT. KIDNEY STONE.
EXAMPLE OF .. ERROR OF
OMISSION IN UROLOGIC
DIAGNOSIS.

of such a case, which should make it clear that the sins of omissions in diagnostic efforts may bob up to embarrass the urologist himself.

This patient was referred to me because of frequent and painful urination. These symptoms were of four days duration. She had been treated previously for back pain (Figure I) over a period of three or four years.

For the four days prior to examination she had voided every few minutes during the day, but only about once each night. Associated with such discomfort was a bearing down sensation in lower abdomen which was not relieved after voiding. Termination of voiding was accompanied by severe cutting pains in the urethra and exaggeration of pain in the left back and kidney region. The history was negative for pain in the right kidney area or other illnesses of note.

Examination revealed considerable inflammation and constriction of the urethra. The urine was highly acid and loaded with pus cells. Cystoscopic examination revealed a rather high grade cystitis and reduction in bladder capacity. Ureteral catheters passed readily to each renal pelvis. The left specimen showed the characteristics noted in the bladder urine. That from the right was essentially normal.

On the basis of such evidence (incomplete you will see later) she was placed on a sulfa preparation and alkalinization therapy which gave such prompt relief that she failed to return at the appointed time. She did return once at a later date for permission to renew her medication.

Then just one year after her first visit she was referred by another physician with a ready made urologic diagnosis. At this time she had a painful mass in the right side, easily palpable, and an x-ray film showing a large opaque shadow in the right kidney area.



^{*} The third of a series prepared for the Journal of the Kansas Medical Society.

Thus the error of previous diagnostic omissions was obvious. By failing to get complete urologic evidence, pathology had been permitted to advance which in all likelihood was the basis of much of her trouble.

While the urine of the left kidney had been highly infected at one time, the right kidney, which proved to be nonfunctioning, in all probability had a great deal to do with that infectious flare up and the associated symptoms. Also, the so called silent renal calculi have been known to cause acute pain in the opposite kidney area.

The completed urologic study brought out evidence as presented by Figure II. The left kidney shows compensatory enlargement. Its function was good as determined by indigo carmine intravenously. The right shows destructive changes associated with a large calcuous in the pelvis and lower pole of kidney. None of the dye returned from this side.

Operative difficulties were encountered in mobilizing the kidney because of extensive thickening and adherance of the perirenal capsule. Convalescence was satisfactory and there has been no complaint of left back pain since removal of the right renal pathology.

The features of this case are presented chiefly because of errors that accumulate by reason of inadequate diagnostic data. While this case is not strictly a viscero urologic complex, it serves to suggest how easily and completely one may be misled by the symptomatic relief sometimes attained by chemotherapy.

An additional reason why diabetes should be kept under strict control is suggested by a report by James R. Lisa, M.D.; Morton Magiday, M.D.; Irving Galloway, B.S., and James Finlay Hart, M.D., New York, in The Journal of the American Medical Association for September 19 that arteriosclerosis or hardening of the arteries is more common in diabetic than in nondiabetic persons. Their findings were based on a postmortem study of 193 diabetic and 2,250 nondiabetic patients.

Among their other findings are that arteriosclerosis is more frequently severe in diabetic than in nondiabetic persons; severe arteriosclerosis is more frequent among persons with diabetes at all ages, and that "sclerotic (hardening) changes in both the diabetic and the nondiabetic person increase in frequency as age advances, but among persons with diabetes a given frequency of these changes is reached about ten years earlier than among those without the disease. . . ."

Even after 1,000 days of war the health of the nation is in many respects better than it was in peacetime. Tuberculosis, however, is an exception.—The Minister of Health for Great Britain, Bulletin, Canadian Tuber. Assn.

CANCER TALKS BEFORE LAY GROUPS

J. L. Lattimore, M.D.

Topeka, Kansas

The Kansas branch of the Women's Field Army for Control of Cancer is doing a fine job in carrying on its educational program on cancer.

The services of the Kansas Medical Society have been offered in this program and every member should be willing to appear before any lay group and present the facts concerning cancer. It is much better that we do this professionally than that others less qualified make these talks.

The editorial board of the Journal has asked me to prepare some cancer facts which may be presented to lay groups, believing that many of you are too busy to gather the material but will be glad to make cancer talks if the facts are assembled for you. Every physician appearing before such groups should be very careful of his approach and the following introductory statement is suggested:

"I appear before you today, representing the medical profession. The knowledge I give to you about cancer is the knowledge of every physician. In no way do I hold myself out as a specialist in this field."

It is well to remember that the terms we use are often not understandable to the layman and cancer facts with which we are well acquainted are unknown to them, so present your material in simple, understandable language. At the completion of the talk give the group an opportunity to ask questions but it is wise to limit the questions to the subject of cancer as they will often get into discussion of other medical problems.

The English word "cancer" comes from the Latin word "cancer" meaning "crab." The word "malignant" means incurable and the layman often uses the term cancer to convey the idea of malignant growth. As physicians we know that there are certain cancers that can be cured, others that cannot.

Cancer is a very old disease having been described in the early writings of Egypt and India. All races are affected by it but it is more prevalent in civilized races whose life span is longer. No doubt a part of this picture is because we have extended life into the cancer age, which is considered from forty-five to fifty-five, but cancer is observed at all ages. Although it is considered an adult disease, infants are sometimes born with cancer. Most physicians believe that cancer is not inherited, however, it does occur more frequently in some families than in others. Cancer ranks second as the cause of death in the United States, being exceeded only by heart

disease. There are approximately 135,000 cancer deaths in the United States each year.

Every cancer starts from a single cell and for some unknown reason, it starts to grow independently and atypically. Thus every cancer must, in its early stages, be very small and if taken at this time a great number can be cured. No one knows the cause of cancer but there is considerable scientific evidence to indicate that cell irritation and inflammation plays an important part, such as a jagged tooth, a hot pipe stem and certain types of work as in a paraffin plant.

It is exceedingly difficult to make a diagnosis of cancer in the early stage but usually with intensive study and observation most cases can be diagnosed comparatively early. Pain is often not present and thus the patient may have a cancer yet never complain of any distress. It is seldom that the patient has fever with cancer until an advanced stage when other complications have arisen. Hemorrhage may or may not be present early, but most certainly hemorrhage, except normal menstrual flow, is always indicative of some disease and should be cause for a complete physical examination.

Often the patient mistakes a cancer for hemorrhoids or piles. She might mistake her vaginal bleeding and think it menopausal. Any gastric discomfort such as so called acid stomach, belching, etc., should be cause for examination. Seldom do they have gastric hemorrhages from cancer until an advanced stage. Cancer of the skin may affect any part of the body, more frequently, however, it affects an exposed surface. Any skin lesion appearing upon the body and remaining more than two weeks most certainly is not the ordinary pimple, cold sore, boil, etc., and justifies a thorough examination to determine the cause. Fortunately our present treatment methods will cure most skin cancers if diagnosed early. There is no absolute test for cancer except to remove a portion of the growth and see if cancer cells are present. The blood shows no change, except anemia in advanced stages and anemia may be present in many other diseases, thus the blood gives no help in making a diagnosis. X-ray aids at times in making a diagnosis of early cancer. The most dependable method of diagnosis is through a thorough examination, the finding of the atypical growth, and removal of a portion of the growth for microscopic

Food plays no part in the production of cancer. Aluminum cooking utensils do not produce cancer. Trauma likely plays a small part. A few authentic cases of traumatic injury show an end result in sarcoma, a form of cancer. Cancer is not transmitted from one person to another, such as through kissing or body contact. Alcohol does not produce cancer. In women, the most common sites of cancer are

the cervix (explain what the cervix is) and the breast, while in men the most common are the skin and the prostate.

Cervical cancer can be diagnosed early, thus showing the urgent need for routine examination of women, especially in the cancer age. Breast cancers occur as a small lump in the breast. Most lumps are not cancerous but to be safe all lumps should be excised and examined.

Hemorrhoids do not become cancerous but so often the patients think they have hemorrhoids, when in fact they have an early cancer, that it is never wise to wait and observe such conditions without the advice of the physician. Bleeding is not always an indication of cancer but again it is a warning of some abnormal condition and should warrant a thorough physical examination.

Treatment of cancer employs either radium, x-ray or surgery. The type of treatment or a combination of treatments can be determined for the individual case after examination, determination of the location of the cancer, the type of cancer and the physical condition of the patient. There is no serum, internal medication or hypodermic that has any value in the treatment of cancer. There are several cancer quacks using paste, which is worthless, except in some innocent skin cancers which can be cured with any type of caustic paste or solution.

There are many things that people can do to prevent cancer. There are many lesions observed under the microscope which are called precancerous. In these, the cells show only minor changes in size, shape and nuclear formation, indicating some type of cellular irritation. These conditions, if treated, either cauterized or removed, will remove the irritated cells and prevent cancer in that location. Socalled mouth canker-sores, leukoplakia is a good example, if treated will disappear; if left untreated, many will often go on to definite cancer. Sores on the cervix (cervical erosions) will often progress to a definite cancer. The best prevention of cancer lies in an early consultation with a physician about any abnormal growth or early atypical findings. Routine physical examination will often reveal lesions which would later lead to cancers.

In giving a talk to the layman try to visualize their attitudes and anticipate their questions and answer them. No doubt every physician has been asked thousands of questions about cancer and all of these may be incorporated in a fine talk which will be appreciated by the lay group and do much to aid in the cancer fight.

President's Page

To the Members of the Kansas Medical Society:

For several years there has been a rather widespread feeling among American physicians that we have failed in one detail—in not having an office in Washington through which Congressmen would have access to accurate facts about medicine. It seemed to me that we might be on the right road last year when, at the House of Delegates of the American Medical Association, this matter was presented. As a result of that discussion the council on Medical Service and Public Relations was established. This council is composed of the very highest type of interested men but it seems that it requires a long time to get such a council organized to the point of rendering the type of service many of us desire. The council will soon have been created a year but I understand that they do not contemplate a Washington office for this year, right at a most crucial time in our medical history.

Originating in California and spreading to many other states there has been organized the United Public Health League. The background of the idea is sound and deserves cooperation by our profession. They have opened a Washington office under the direction of Ben H. Read, a former newspaper man, who for several years has been connected with the California Medical Society. Thru this office, they plan to disseminate medical information. From what I have been able to learn Mr. Read is a very able man and no doubt will render a fine service.

It appears, however, that if this plan were followed a little further, we might have a number of different groups in Washington, all offering a similar service; then our Senators and Congressmen would really be in a dither as to which group offered correct information.

I can hardly offer a criticism of the Public Health League for they are merely doing the thing that the American Medical Association should have done years ago and could have done this past year if they had desired.

Most certainly the League is attempting to help medicine, right at the time when we need help badly, so it seems probable many physicians will support the League in its efforts until such a time as the American Medical Association takes over the same type of work.

Sincerely,

President, The Kansas Medical Society

J. L. Lattemore W.

EDITORIAL

RED CROSS WAR FUND

The 1944 drive for war funds for the American Red Cross will be carried on in every town and county in the country this month. It is the duty of every physician and the family of every physician to give active support to this drive for funds. Contributios are necessary to maintain the splendid work the Red Cross is doing both on the war front and on the home front in case of disaster.

The Red Cross is the agency under whose supervision approximately 2,500 nurses will be enlisted each month for Army and Navy service. They have supervised the training of thousands of nurses aids to take the place of the nurses that are needed on the war front. They have trained first aid workers, conducted surgical dressing units, organized knitting groups, prepared bundles for war stricken countries, and maintained blood banks with more than five million donors contributing blood for our men in service.

The soldier and sailor knows that the Red Cross is his first and fastest contact with his family at home in personal emergency. He finds Red Cross workers in field offices, in recreation centers, in dressing stations, in canteens and in fox-holes at the front giving comfort and aid wherever they are needed. The Red Cross is the one contact a war prisoner has with his family and friends at home.

Don't wait. Contribute today to the American Red Cross.

ACTION IN TIME MEANS LIFE

It has been stated that cancer is the most curable of the fatal diseases. That is an interesting statement and is not a contradiction of itslf, as it might at first seem to be. Its justifications lie in the nature of cancer itself—for cancer in its early stages is localized, limited, and capable of being completely removed or destroyed.

Cancer in its last stages is as sinister as a disease can be. It is widespread and has invaded surrounding tissues with ill-defined irregular strands of abnormal growth. If untreated and unchecked, cancer is uniformly and universally fatal. It is this grim fact that brings out the contrast between early and late stages of the disease.

The picture, however, is far from being a gloomy one. Each year more people are learning that "time" is the key word in cancer control. Each year thousands of people are coming to their doctor with very early signs and symptoms that may mean cancer. As a result they are being trated in time to prevent cancer or to cure it if it has started. The value of an annual or semi-annual physical examination is becoming clearer to an ever-increasing number of men and women. The Women's Field Army of the American Society for the Control of Cancer is growing yearly at a faster rate. Today three hundred thousand women throughout the United States are enlisted in the fight against cancer—the fight to bring knowledge and confidence into every home in the country.

Cancer Prevention Clinics—where perfectly well persons report periodically for a physical "check-up"—have been established in some cities and are doing excellent work. The idea will spread and grow. Lives will be saved, suffering avoided. Death will be cheated. Americans of the future will visit such clinics as a matter of routine.

It is well when the world is darkened by the fierce storm clouds of war to remember that there are men and women working quietly but tirelessly to allay fear and to bring peace and hope to hundreds of thousands of people—to your friends and mine—to your family and mine—perhaps to you and me ourselves.

For thirty years the American Society for the Control of Cancer at 350 Madison Avenue, New York City, has been the leader in this campaign. It will gladly provide, without charge, information which you may desire. It asks you to enlist in the fight against cancer for your own sake as well as for those whom you may be able to help. Do not delay. Remember that in cancer "action in time means life."—C. C. Little, M.D., Director of the American Society for the Control of Cancer.

COUPONS

The Journal has a great responsibility to its readers and alike to its advertisers whose names appear with great regularity in its pages each month. One wonders if doctors of medicine are alive to the importance of the coupons attached, from time to time, to these advertisements. Firmly we believe that the medical profession as a whole is without doubt the worst offenders when one hears these remarks: "Don't want to tear my medical journal up," "I never send for samples," and "Too busy now, can't take the time."

We believe these excuses are true, but try penciling a note to your office girl to send for samples of the product advertised.

A coupon, acording to a recent definition is "a separate part of a certificate, a ticket, etc., entitling

the holder to something." Perhaps that something is a new product, maybe the very thing you've been hunting for Mrs., that patient of yours, but at least if you send for it the advertiser knows that you have read his advertisement in the Journal of the Kansas Medical Society.

The Journal is yours. The products advertised in it are accepted and approved by the editorial board and the committee on pharmacy and chemistry of the A. M. A. and the Cooperative Medical Advertising Bureau and are the best that can be found in any country in the world today. Therefore, when you mail in an advertising coupon or send for a sample or booklet, you announce your approval and interest in your publication. Don't forget that the advertiser helps to make your Journal possible.

Mail coupons from the Journal often.

THE TREATMENT OF MENINGO-COCCIC MENINGITIS

During the first World War there were in the United States Army a little less than 6,000 cases of meningococcic meningitis in the course of thirtythree months with a mortality of thirty-nine per cent. Following that war the cases among the civilian population of the United States continued for ten years at a high rate, but by 1930 the instance of cases had fallen to its usual prewar level. For the years 1939, 1940, and 1941 slightly less than 2,000 civilian cases per year were reported for the whole country. In the year 1942, however, there was a notable increase until a little less than 4,000 cases occurred during that year. The logical explanation for this rise was the mobilization of troops. It was an accepted conclusion therefore that with the increasing mobilization a proportionate increase in the number of cases could be expected. The incidence of meningococcic meningitis both in the Army camps and in the civilian population has in every way fulfilled these expectations. Fortunately, however, the perfection of the sulfonamide drugs has made it possible to reduce the amazingly large mortality of the first World War to approximately 3.5 per cent. We are therefore no longer confronted with the fact that one in every three must die as was the case in the first World War. A very considerable literature has accumulated from which encouraging conclusions can be drawn concerning the management of this hitherto serious disease entity.

In most of the reports there is evidence which indicates that the seasonal incidence of the disease seems to run in a definite pattern. Few cases are seen in the summer months, but as the fall weather begins there is a sharp rise and a peak is reached

in about the middle of January. From then on a gradual fall over the months of February, March and April is noted until the incidence again levels off during the summer months.

One definite opinion expressed in the reports of the treatment of meningococcic meningitis during 1942 and 1943 is that treatment with the chemotherapeutic dugs is most successful when it is started early. Consequently the early diagnosis of the disease is of paramount importance.

It should be borne in mind that meningococcic meningitis is primarily a septicemia without any clinical evidence of meningeal involvement. In the acute fulminating type all orderly symptoms are masked in the profound shock and early coma which usually ends in death. Otherwise the conventional symptoms appear in a more or less definite sequence. In the early stages of the average case a course is followed which is very similar to the symptoms encountered in ordinary upper respiratory infections which are likewise so common during the colder months. Conspicuous among these symptoms are sore throat with headache, chilliness or chill, backache and muscle ache. If the clinical picture, however, changes so that restlessness and drowsiness are outstanding symptoms and if the headache becomes more severe and is accompanied by nausea and vomiting, particularly of the projectile type, meningitis should be suspected. If this is true these symptoms are followed shortly by rigidity and soreness of the neck on either lateral or forward motion. Next the blood count usually determines whether or not the patient has meningitis or has a simple grippal infection. A sharp increase in the white cell in contrast to a leukopenia usually rules out grippal infections and suggests meningitis. An immediate lumbar puncture is then indicated for diagnostic purposes and a laboratory examination should consist of a smear, culture, cell count and sugar content determination. The laboratory examination may be negative at first only to reveal positive findings in subsequent punctures. Cutaneous symptoms may develop at this stage and may consist of petechial or ecchymotic lesions. These lesions may become hemorrhagic. Cutaneous lesions may be entirely absent in an otherwise well-defined clinical case of meningococcic meningitis.

After having made a provisional diagnosis, there should be no delay in instituting chemotherapeutic treatment even through the spinal fluid is negative at first. The amazing reduction in mortality from thirty-nine per cent in the last war to less than 3.5 per cent in the present war may be definitely credited to chemotherapy. It is true that in some desperately ill patients the inclination to supplement the sulfonamide drugs with serum becomes irresistible but the

opinion is widespread that in ninety-five per cent of all patients chemotherapy properly administered is the only treatment required.

All of the common sulfonamide derivatives have been used. These include sulfanilamide, sulfapyridine, sulfathiazole, sulfadiazine and more recently sulfamerazine. Sulfadiazine seems to be the most satisfactory and consequently the most popular drug in the treatment of the disease. Sulfamerazine may be equally effective after it is used in a greater number of cases. Experience, however, has shown that when the response to one of the sulfonamide derivatives is not satisfactory another should be tried immediately before the effective blood level of the first changes appreciably. The dosage of sulfadiazine for adults consists of an initial dose of four to six Gm. in mild cases to eight or ten Gm. in severe cases. This should be followed by one Gm. every four hours. Children are given approximately one grain per pound of body weight per day (0.13 Gm. per Kg.) after the initial administration of about 1/2 of the 24hour dose. All patients should receive the drug by mouth except those who are unconscious or where severe vomiting exists. When this occurrs the drug may be given in the form of the sodium salt intravenously. Intravenous sodiumsulfadiazine should be given slowly in a one per cent solution in distilled water or isotonic salt solution. Blood level determinations are desirable when the drug is administered intravenously. The level should be kept under fifteen mg. per 100 cc. A difference of opinion, however, exists concerning this and some permit it to go higher. In every case fluid intake and output charts should be kept. Fluid intake should be maintained at about 3,500 cc. to 4,000 cc. and the output at 1,200 cc. to 1,500 cc. daily. Daily urinalysis, drug level determinations and white blood count should be made. There should be no trouble in dong this if adequate laboratory facilities are available.

If facilities for daily drug level determinations are not available, it may be reasonably assumed that adequate levels can be maintained in the dosage of sulfadiazine given. There can be no excuse, however, in private practice for omitting daily urinalysis and white blood count. When sedatives are indicated some of the barbituric acid preparations may be utilized. Most observers believe that morphine and codeine should be avoided because of their depressive action on respiration.

In those few instances where the belief exists that meningococcic antitoxin should supplement chemotherapy, 50,000 units in 200 cc. of ten per cent glucose may be given intravenously every eight to twelve hours. Among those who continue to advocate supplemental serum therapy the average amount has varied from 150,000 to 450,000 units. Patients in

which septicemia continues seem to be benefited by meningococcic serum. Nevertheless, the variability of the strain of organism in different cases continues to make serum therapy questionable and the excellent results obtained with sulfonamides has popularized the belief that serotherapy is of little additional value.

All treatment should be continued for from three to five days after the patient becomes afebrile although the dosage may be decreased slowly after the second day of normal temperature.

It is gratifying to know that meningococcic meningitis as a problem in the present war has become comparatively simple when the mortality rate is considered. Twenty-five years ago one in every three died and now ninety-five out of every 100 live. There is reason to believe that even more may be saved if early diagnosis is made so that treatment can be instituted immediately in the first stages of the disease.

—The International Medical Digest, January, 1944.

SALERNO

The place that figures so prominently in the news of today, played a significant part in the history of medicine. The School of Salerno flourished from the beginning of the ninth to the end of the fourteenth century. Like Montpellier in the beginning, Salerno was purely a medical school. Its origin is veiled in mystery. In the fourteenth century it was overshadowed by Montpellier and Bologna and was finally put out of existence by Napoleon. In its heyday it attracted students from all over the world so that it merited its medieval name, Civitas Hippocratica. It is noteworthy on six counts: 1. As the place where lay medicine emerged from ecclesiastic domination; 2. It was at Salerno that decadent Greek medicine was rejuvenated by Arabian learning; 3. The first medical-practice act in the western world (Persia may have anticipated Salerno) was enacted at Salerno. The home of Roger of Parma, the Surgeon; 5. Trotula; and, 6. The Regimen Sanitatis Salernitanum.

In the middle ages all knowledge, including Medicine, was confined to the monasteries. The monks practiced medicine on the side, often going outside the monasteries to practice their healing art. This took them away from their religious duties so that various Church Councils in the XII century restricted this practice and finally stopped it entirely. Among the monastery schools in which medicine was taught, the nearby Benedictine Abbey of Monte Casino was famous in the ninth century. Yet, in the School of Salerno most of the teachers were laymen. Jew, Saracen, Greek, and Roman met on equal terms. In fact,

there is a tradition that the four founders were equally divided among these races.

The stream of Greco-Roman medicine had almost run dry when about 1077 Constantinus Africanus located at Salerno and brought with him an encyclopedic knowledge of Arabian medicine and a collection of manuscripts which he began translating. His translations of the Aphorisms of Hippocrates, some of the works of Galen, and the Royal Book of Ali Abbas tremendously stimulated medical writing. Medicine, surgery, and anatomy were revolutionized by these new books. To the Arabian scholarship the Salernitans contributed a direct, practical attitude.

After Constantine the fame of Salerno spread rapidly. This was due in some measure to the interest that the rulers of the two Sicilies took in the School. As early as 1140 King Roger decreed that a physician before beginning practice should get the approval of the royal authorities "in order that the King's subjects should not incur dangers through inexperience of their physicians." Roger's grandson, Frederick II, made very explicit laws governing the teaching of medicine. Before anyone entered the study of medicine, he had to have three years of philosophic and literary studies. The medical course, itself, extended over five years and was followed by one year of assistantship to an experienced practitioner. He then came up for his examination before the University authorities. It all sounds quite modern for the Middle Ages.

In the middle of the twelfth century Salerno had a celebrated surgeon by the name of Roger of Parma. His teachings and conversations were taken down by his students and became the Surgery of Roger. This was used not only at Salerno but at Bologna as well, and its various modifications became the "Surgery of Roland," the "Surgery of the Four Masters," etc. The treatment recommended for injuries of the skull, stone in the bladder and goiter, is especially noteworthy. The book was regarded as classic for three centuries.

The most famous of all the works of the Salerno School is the Regimen Sanitatis Salernitatum, a didactic poem covering hygiene (anatomy, physiology, materia medica, etiology, significance of different signs, pathology, therapeutics, nosology, and practice of medicine. The famous poem was translated into many languages and went through nearly 300 editions, one of which contained 3,520 verses. The following lines are from the translation of Sir John Harington:

The Salerne Schoole doth by these lines impart All health to England's King, and doth aduise From care his head to keepe, from wrath his heart, Drinke not much wine, sup light, and soone arise, When meate is gone, long sitting breedeth smart: And after-noone still waking keepe your eyes, When mou'd you find your selfe 'o Nature Needs, Forbeare then not, for that much danger breeds, Vse three Physicians still; first Doctor Quiet, Next Doctor Merry-man and Doctor Dyet.

TUBERCULOSIS CONTROL

TUBERCULIN TEST, X-RAY AND OTHER DIAGNOSTIC AIDS

There is now a strong tendency to "diagnose" tuberculosis by short-cut and sometimes slipshod methods. Recently, a few physicians were asked how they would proceed to find all of the tuberculosis among the population of an entire industry or county. One stated that increased red cell sedimentation rate would ferret out all cases. Another would discover them by finding acid-fast bacilli in their sputa. Still another would employ only x-ray film inspection of their chests. Other similar methods were offered. Each physician presented an important phase of an examiation, but not one of them was adequate. To achieve a satisfactory diagnosis each one of this group of physicians would have to examine a given individual in his own way, then pool his findings with those of his colleagues—a wasteful and illogical procedure.

There can be no tuberculosis in the absence of tubercle bacilli; therefore, the first phase of an examination is to determine whether bacilli are present. This can be done by the tuberculin test, which is accurate and specific except in the first few weeks after infection occurs, and in acutely ill and terminal cases. Other failures are usually due to the use of important tuberculin or to improper administration. Under proper conditions, then, a non-reactor to tuberculin can be told that he does not have living tubercle bacilli in his body. On the other hand, a reactor has at least primary lesions which centain living tubercle bacilli. Exceptionally, and only when all bacilli die, allergy persists for a time, then wanes and disappears. Inasmuch as primary tuberculosis is a prerequisite for the clinical forms, it is of extreme importance to know whether it is present. The tuberculin test provides this information with uncanny accuracy. With the exceptions mentioned, it is with great rarity that the person with clinical tuberculosis fails to react to tuberculin.

The next phase of the examination consists of inspecting the chests of all adult reactors with the x-ray.

On the ordinary film twenty-five per cent of the lung parenchyma is obstructed from view by shadows of such parts as the heart and diaphragm. Films fail to reveal evidence of primary tuberculosis in seventy to eighty per cent of the persons in whom it actually is present. So, too, may lesions of the reinfection type, because of their size and consistency, escape detection. It is a common experience to view a film which appears clear, yet one of the same chest a few months later reveals evidence of disease. Therefore, adult tuberculin reactors whose lungs appear normal should have films at least annually.

After tuberculous lesions of the reinfection type attain macroscopic (gross) proportions, x-ray inspection is by far our best method of detecting their locations when they are in that part of the lung which is visualized; indeed, they cast shadows on an average of two to three years before they cause significant symptoms. However, final diagnoses should never be made from x-ray shadows, since those cast by tuberculosis lesions may be indistinguishable from those of numerous other pulmonary diseases, such as sarcoidosis, silicosis, malignancy, fungus infections, abscess, and pneumonia. When a lesion is found, its etiology can usually be determined by other methods.

The present, widely used procedure which begins with x-ray inspection of the chests of large groups of adults is laudable, provided it does not end there. All concerned must be informed that (1) x-ray inspection is done with the unaided eyes and reveals nothing but macroscopic (gross) lesions; (2) one-fourth of the lung parenchyma is obstructed from view by shadows of other parts; and (3) final diagnoses cannot be made with accuracy from x-ray shadows. Thus, the tuberculin test screens out those persons who have living tubercle bacilli in their bodies, and from them the x-ray screens out those who have gross lesions which may be tuberculous. Neither nor both procedures constitute an adequate examination.

To determine whether a demonstrable lesion is tuberculous one must seek tubercle bacilli in material obtained from it. Among individuals with extensive tuberculous lesions these are usually promptly recovered from the sputum. When bacilli are not found in more than one of several specimens, or if no sputum is present, gastric lavage may reveal their presence. Visualizing acid-fast organisms by the aid of the microscope may not be sufficient because of laboratory errors and also because nonpathogenic, acid-fast bacilli are sometimes found in the sputum and gastric contents; therefore, their pathogenicity should be determined by culture on artificial medium or by animal inoculation. In the event tubercle bacilli or other pathogenic organisms are not recovered, one should observe frequently new x-ray films to determine whether abnormal shadows persist or any significant changes occur in or around them. However, among persons beyond thirty-five years one should avoid delay, as the lesion may be malignant. In such cases the bronchoscopist should be consulted, as he may promptly reveal the etiology.

There is no more deplorable practice than to have tuberculin tests administered and x-ray films prepared, after which the physician makes diagnoses without seeing the subject and completing the examination. The individual should always be interviewed by the physician. While most persons have no symptoms for an average of two to three years after the disease can be located and practically none of those with primary tuberculosis give histories of significant illness, the tuberculin reactors whose chest films are entirely clear may relate symptoms caused by extra-thoracic tuberculosis. Indeed, they may be developing acute conditions, such as meningitis or miliary disease, or chronic lesions in such parts as the kidneys, pelvic organs, and bones and joints.

Following the iterview, even though no significant evidence is obtained, the remainder of the traditional physical examination should be made, since significant pulmonary signs may be elicited from lesions located near the periphery or in parts of the lungs not visualized by x-ray; moreover, lesions may be found during the scrutiny of extrathoracic regions.

To summarize: Tuberculosis begins when the first tubercle bacilli enter the human body and are focalized in microscopic lesions. At this stage the disease may lie dormant or may even disappear. Again, it may undergo exacerbations and remissions resulting in every form of clinical tuberculosis to which the human body is heir. The physician can now diagnose tuberculosis within a few weeks after the first invasion of tubercle bacilli, and he can detect most of the subsequent lesions with considerable promptness. Either to diagnose tuberculosis when it does not exist or to fail to find it when it is present, is inexcusable. Nearly all errors in diagnosis are due to shortcut or slip-shod methods and may be avoided by employing every phase of a complete examination.— From Tuberculin Test, X-ray and Other Diagnostic Aids, J. A. Myers, M.D., Journal-Lancet, April, 1944.

Oliver Wendell Holmes is known to the world as a poet, essayist and philosopher. Yet he received his medical degree from Harvard University in 1836 and practiced until 1857 at which time his "Autocrat of the Breakfast Table" began to be published in the Atlantic Monthly. Holmes was by no means Boston's most famous doctor, but he was certainly the most famous Bostonian who ever practiced medicine.—Bulletin of the Women's Auxiliary to the American Medical Association.

MEN IN SERVICE

The men in service column, we are told, is the first part of the Journal to which our own men in service turn when the new Journal arrives. Some of you are corresponding with men from your home town in service and parts of these letters would be interesting reading for others likewise. If you have such a letter will you be kind enough to loan us at least a part of it for printing in this column. One officer writes that it gives him a good idea where the other members are and what they are doing and makes interesting reading.—THE EDITOR.

Major Charles E. Basham of Eureka who has an APO address out of Los Angeles writes us: "My copies of the State Medical Journal have been forwarded to me from Eureka. Will you send my Journal to the above address. I enjoy the papers in the Journal very much as well as the military columns and the editorials. Reading the Journal keeps me in touch with the medical affairs of my native state. At the present time, I am a member of the staff of the 34th General Hospital in the position of Chief of the General Surgery Section of the surgical service. It is a wonderful assignment and I am proud to be a member of this great unit. Best of luck to you, in the coming months of this year." Congratulations, Major Basham, and thanks for your letter.

Dr. Norman A. Burkett, county health officer for Geary County with offices in Junction City has resigned his position to accept an Army commission as lieutenant in the medical corps. Dr. Burkett left for service on March 8.

Lt. Comdr. Harold 'Holter of Kansas City was in Pensacola, Florida, recently where he was awarded his commission as a flight surgeon in the Navy.

Dr. Clifford VanPelt of Junction City has closed his office to accept a commission in the Navy Medical Corps. Lt. Van Pelt is the son of Dr. Clifford L. VanPelt of Paola.

Capt. J. Allen Howell of Wellington is stationed at Ft. Logan, Colorado. Captain Howell was recently commended for his work in the orthopedic department of Lincoln Army Air Field Hospital where he was stationed before being transferred to Colorado.

Capt. John Nienstedt of Hartford who has seen service in North Africa and Italy has recently been returned to the United States because of malaria and is now in the Coral Gables Hospital in Miami, Florida.

Major K. W. Haworth, formerly county health officer in Pratt was home on a short furlough from dessert maneuvers.

Capt. Herbert L. Songer of Lincoln who is now stationed in England wrote home that he had spent a recent furlough in London and had visited some of the hospitals while there.

Capt. Leslie L. Saylor of Topeka has advised us that he has a change in stations and is now with the 71st Station Hospital with an APO out of San Francisco.

Lt. Col. R. W. VanDeventer of Wellington has been transferred to the Veterans Administration Facility at Muskogee, Oklahoma, from Camp Carson, Colorado.

Captain Edgar P. Sereres of Kansas City was graduated as an aviation medical examiner on January 6 from the School of Aviation Medicine at Randolph Field, Texas.

From the February 5 issue of the Journal of the American Medical Association, Lieut. Col. Edward Hashinger, home on leave to Kansas City, Missouri, from oversea duty has the following to say in regard to the Kansas evacuation unit. "During its eighteen months overseas the outfit served throughout the Tunisian campaign from the landing at Oran and handled thousands of battle casualties. During the invasion of Sicily a number of the younger officers and enlisted men were assigned temporarily to the Navy to serve on landing barges. They were given citations by the Navy for meritorious service in the landings at Gela and Licata. Each member of the unit wears three campaign stars on the European theater ribbon, one for invasion and one for the South Tunisian and another for the Sicilian campaign. In Sicily the unit functioned as a hospital, handling medical cases such as malaria in the rear. They had no casualties other than a few patients with malaria, who quickly recovered, although there were more than forty air raids in the vicinity of the evacuation hospital unit. At the conclusion of the Sicilian invasion the unit was transferred to England, where it is at present. The unit consists of approximately 50 medical officers, 50 nurses and 300 enlisted men. Practically all of the personnel are from Kansas City or the immediate territory, and many officers are from the University of Kansas hospital staff. Major Tony G. Dillon of Kansas City is now the executive officer of the unit."

"Somewhere in New Guinea"—The November issue of the State Medical Journal just caught up with me. It makes real good reading down here in the Jungle. I was especially interested in the comments concerning blood plasma and its uses taken from the article of the Indiana major. Nothing is so comforting to the medical officer as the presence of an adequate supply of bottles of dried blood plasma. It truly is the outstanding achievement of the medical department of the Army. They are saving many lives right in the foxholes and swamps or wherever they fall. The Red Cross deserves the support of everyone in their campaigns for donations of blood. Please change my APO to as it is good to hear of things back home. Sincerely, Virgil E. Brown, Capt., MC." Captain Brown formerly lived in Sabetha.

Capt. Homer S. Foutz of Minneapolis has been transferred from Sheppard Field, Texas, to an APO out of San Francisco.

Dr. W. M. Mills of Topeka received an interesting letter recently from Major Orville R. Clark of Topeka concerning treatment of wounded on the Italian front.

"Our main concern is the prevention of infection, control of bleeding and making them transportable. It is a change from the control or treatment of infection which was one of our chief problems in the farther rear surgery when I was at the British hospitals, for this is primary surgery. My first stop in one of the Evacuation hospitals dur-

ing December was at a different unit.

"Here it is run on a different principle-all the cases which have not yet been operated are kept in a special preoperative section ('shock wards,' tho not all of them are in shock by any means). All the surgical teams are on duty at specified times on a rotating schedule of eight hours each, of course longer if they begin getting behind. The teams on duty work in O. R. and cases are fed into them from the shock wards—as they finish up one, another one comes in. This part is taken care of by the Chief of Surgical Service most of the time and another of the men to relieve himacting as a sort of master of ceremonies or shop foreman. He keeps things moving along-and he does! By this scheme we don't waste time running back and forth to ward and x-ray and O. R .- as the patients are all x-rayed before we see them. It seems to work very much better for us. And the other advantage is that the individual teams do not have a long list of patients they are 'behind' -whatever is yet to be done, the whole hospital is behind. It lightens a load on individuals. Of course all our cases go to our own ward and all take care of the post-op care until they are evacuated.

"I remember one German prisoner with a compound femur who had been lying on the field four days before he was splintered and picked up. Why he wasn't badly in-

fected, I'll never know.

"Here there are some orthopedic teams that take on the worst of the orthopedic cases. We have had some tibeas and forearms, but have escaped the femur and humerus here. The large percentage of all of them are of course soft tissue wounds of extremities—some quite 'minor.' However, I never feel that I am slighted by having 'minor' cases. They are as deserving of careful treatment as any of them and I can handle a large number if that is the type of case.

"The biggest disadvantage is that we have to evacuate them before we know what sort of results we are getting from our treatment. But that can't be avoided and we have to rely on what we hear from the rear hospitalss and the official circulars.

"As far as equipment is concerned—instruments, sutures, dressings, plaster, etc.—we have so far had what we needed, tho it is true we learn we can do with less than we were accustomed previously chiefly in linens."

Comdr. Eric E. Larson, chief of surgery at the United States Naval Hospital in Pearl Harbor has been promoted to captain. Comdr. Larson is the son of Mrs. Anna Larson of Topeka and the sister of Miss Julia Ann Larson, R.N., of Topeka. He as born in Scandia and was graduated from Chicago University and the Rush Medical School, received postgraduate training at the Mayo Clinic and was later associate professor of surgery at the University of California.

Lt. Comdr. B. I. Krehbiel has been promoted to commander.

Brig. Gen. Fred W. Rankin of Washington, D. C., in a talk to the Kentucky State Medical Association on current trends in military surgery says: "I believe that the reduction in mortality which is universal in our Army has been the result of, first, the plasma program; second, better surgery;

third, the sulfa drugs; and, fourth, a number of other factors, such as transportation, good care and logistics. Plasma has saved more lives in the Army from battle wounds, than any other single factor."

A letter from the jungles printed in a recent Rhode Island Medical Journal carries some interesting medical information: "We began to receive patients into a motley group of bamboo huts ('bashas') on what had recently been marsh in virgin jungle. Fortunately, the 'dry' season (relatively, actual dryness never exists here) supervened, and our greatest initial problem, the engulfing mud was solved. Our facilities were so limited at first that we had one ward with patients, but without a roof.... We had no nurses, and very few of our enlisted men had been trained in hospital work. But many of these ex-farm boys and pristine coal miners set in with a will to learn to read thermometers, give enemas, assist in operations, and all the tasks commonly assigned to nurses. Many of them have become quite proficient, even in this short time. As you can imagine, the long trek supplies have to travel did not ease that problem....Somewhat over one-half the work has been medical (malaria, dysentery, dermatitis venenata, respiratory infections, malnutrition (among the Chinese).... There has, however, been considerable surgical work-mainly on the results of trauma-and a fair amount of dispensary work which includes the Nagas as regular customers. (Parenthetically, the good-will created by American generosity among this primitive hill-folk bears tangible fruit). Within the past week, on two occasions I have treated stranded aviators carried in from the jungles by the Nagas."

Lt. Comdr. L. R. Pyle of Topeka has been promoted to commander.

An Associated Press writer with the Fifth Army has the following to say in regard to war surgery:

"Miracles of surgery are being performed every day by front line physicians operating under hardships which seemingly would defeat any hope of saving lives. Yet these doctors have come to accept the impossible as the normal.

"Many of these doctors have almost forgotten what it is like to operate in a warm, sterile room with indirect lights and everything neatly ordered, but they are developing skill which will give America many great surgeons when the war is ended." As has been said this is "kitchen surgery in the rough."

Lt. H. H. Crank of Topeka has advised us that he is in Farragut, Idaho.

Capt. Arthur J. Revell of Pittsburg writes: "I have returned to the states from an APO address out of Seattle. Will you please send my copy of the Kansas Medical Journal to the Station Hospital, Fort Francis E. Warren, Wyoming."

Commissioning of the United States Army hospital ship Seminole was recently announced by the War Department. A former combined freight and passenger ship, the vessel is 402 feet long and has a gross tonnage of 5,896 and a net tonnage of 3,514. It contains 284 beds for patients and 182 ambulatory patients. The ship is staffed by fifteen medical officers, thirty nurses and eighty-one medical attendants.

In addition it has a Navy crew. The commanding medical officer is ship commander, but the navigation is under command of a naval officer. The Army has two other hospital ships in operation, the Acadia and the Shamrock.—Ohio State Medical Journal.

Major Don C. Wakeman of Topeka has an APO out of New York. Major Wakeman was last stationed at Fort Leonard Wood, Missouri.

Lt. Comdr. C. H. Warfield of Wichita has been transferred from Great Lakes, Illinois, to Brooklyn, New York, where he is with a United States Naval Mobile hospital.

Major F. T. Renick of Lawrence is not located at San Antonio, Texas.

Major William Scales of Hutchinson had been transferred from the station hospital at Hammer Field, Fresno, California, to Blytheville, Arkansas.

Lt. Col. William C. Menninger of Topeka has a new address in Washington, 1818 "H" Street, N. W. Lt. Col. Menninger was tansferred from Atlanta, Georgia, where he was connected with the Fourth Service Command.

Captain Clyde W. Miller of Wichita has been transferred from Fort Bliss, Texas, where he was with the 60th General Hospital and now has an APO address out of San Francisco.

Lt. Samuel B. Muller of Pittsburg, formerly of Overland Park, has a Fleet post office address out of San Francisco.

Major G. S. Ortman of Kansas City has been transferred from Albuquerque, New Mexico, to Glendale, California.

Capt. H. M. Floersch of Kansas City, stationed at Fort Leonard Wood, Missouri, now has an APO address out of New York.

Lt. G. F. Helwig of Topeka has been transferred from the Navy Recruiting Station at Salt Lake City, Utah, to the Navy Unit at the Washburn Municipal University at Topeka.

Capt. Edwin W. Enders of Lawrence sends us an American Red Cross post card from "Sardinia" that he wants his Journal address changed.

Lt. G. E. Staford of Salina has been transferred from Lincoln, Nebraska, to the Army Air Base at Reno, Nevada.

Of three thousand one hundred fifty-six deaths of physicians reported in The Journal of the American Medical Association during 1943, twenty of the doctors were killed in war action and one hundred five died in military service.

★ BUY AN EXTRA BOND

NEWS NOTES

1944 ANNUAL MEETING

Plans for the 1944 annual meeting of the Kansas Medical Society, which will be held in Topeka at the Municipal Auditorium on May 10 and 11, are rounding up in good shape.

Dr. Dwight Lawson, chairman of the program committee, has announced that the following speakers have been secured for the scientific session: Dr. O. T. Clagett of Rochester, Minnesota; Dr. R. D. Schrock of Omaha, Nebraska; Dr. Archibald Hoyne of Chicago, Illinois; Dr. Edward Massie of St. Louis, Missouri; Dr. M. Edward Davis of Chicago, Illinois; Dr. W. M. Gordon of Kansas City; Lt. Col. Howard A. Rusk of Washington, D. C.; Capt. Donald Campbell of Winter General Hospital of Topeka.

Dr. Leo Smith, chairman of the committee on technical exhibits, has received requests for reservations from the following exhibitors:

A. S. Aloe Company, Kansas City, Missouri
The Borden Company, New York
Gerber Products, Fremont, Nebraska
Goetze-Niemer, St. Joseph, Missouri
Holland-Rantos Company, Inc., New York
The W. E. Isle Company, Kansas City, Missouri
Eli Lilly and Company, Indianapolis, Indiana
Medical Protective Company, Fort Wayne, Indiana
Wm. S. Merrell Company, Cincinnati, Ohio
Ortho Products, Inc., Linden, New Jersey
Parke Davis and Company, Detroit, Michigan
Pet Milk Sales Corp., St. Louis, Missouri
E. R. Squibb and Sons, New York

Wyeth, Incorporated, Philadelphia, Pennsylvania Committee reports and a complete program of the meeting will be published in the April issue of the Journal. Plan now to attend the entire session and make your hotel reservations as early as possible.

FRANCISCO MEMORIAL FOUNDATION

Medical students and faculty of the University of Kansas School of Medicine have started a fund for a memorial to Dr. Clarence B. Francisco of Kansas City whose death occurred on February 23.

Dr. Francisco completed his medical school work at the University and located in Kansas City but left to serve as consulting orthopedic surgeon for the American Expeditionary Forces in World War I with the rank of lieutenant colonel and at the close of the war returned to Kansas City to make his home. At the time of his death he held a commission as colonel in the Army Reserve Medical Corps, was orthopedic surgeon of the Children's Mercy Hospital in Kansas City, professor of clinical orthopedic surgery of the Medical School, chairman of the orthopedic board of the Kansas Crippled Children's Commission, served on the staff and was consulting orthopedic surgeon for numerous hospitals in Kansas City, Leavenworth and Lawrence.

The committees in charge of the memorial hope to collect approximately \$200,000 which will be used to build a student union building on the medical school campus in Kansas City. The proposed building will house the medical library, a cafeteria, recreation center, postgraduate facilities, dormitory and rooms for visiting physicians. The idea for

the memorial originated simultaneously, a few days after Dr. Francisco's death, with the students and the faculty alike, each of which has its own committee for the collection of funds. Dr. Galen Tice is chairman of the faculty committee and Bernard Hall, whose home is in Lawrence but who is now a senior in the medical school, is chairman of the student fund. Dean H. R. Wahl of the University Medical School is the treasurer and other members of the committee are Dr. Ralph Major and Dr. Don Carlos Peete of Kansas City.

Ten days after the idea originated without any solicitation there was \$2,500 in the fund. It is planned that the remainder of the money will be raised by contacting faculty members, physicians in greater Kansas City, students and former students of the school, friends, present and former patients, and groups to which Dr. Francisco has so readily and willingly contributed his time and services. It is hoped that county medical societies in the state will organize their own committees and make personal or group contributions to the fund.

A story was told that following the last war Dr. Francisco was offered several enviable staff positions in clinics located in eastern cities and when questioned about such rumors he was heard to say: "Kansas needs surgeons more than those big eastern cities do." So he came back to Kansas and Kansas has experienced an irreparable loss in his death.

W. F. A. ENLISTMENT CAMPAIGN

The month of April will be given over to the enlistment campaign of the Women's Field Army for control of Cancer. Mrs. J. E. Johntz of Abilene, state commander of the Kansas division and her workers are desirous that every physician and the wife of every physician in the state should enlist in the campaign and wherever possible urge others to enlist also. The lay educational publicity done by the Kansas Women's Field Army in the past few years has been of great value and any assistance the profession can give will, according to Mrs. Johntz, be most welcome.

AMERICAN COLLEGE OF SURGEONS MEETING

Th 1944 war session of the American College of Surgeons for those in this district will be held in Tulsa, Oklahoma on April 4, 1944, at the Mayo Hotel. The College has scheduled twenty-one meetings throughout the country rather than the usual central meeting, and all will be one-day sessions.

The general program will include military motion pictures from 8:30 to 9:30 a. m. followed by War Department talks and discussion of the medical activities of the Navy in the South Pacific and amphibious assault. The Surgeon Generals of the United States Army and the Navy will discuss experiences in the theaters of operation from 9:30 to 11:30 a. m., and a representative of the United States Public Health Service will discuss wartime problems in communicable disease control from 11:30 to noon.

A luncheon for physicians, surgeons and hospital representatives will be held at 12:15 to 2:00 and problems in relation to the accelerated program for pre-medical and medical education, and current problems of medical manpower for the armed forces, hospitals and the civilian population will be discussed.

The following subjects will be discussed at the afternoon session: war wounds of the extremities, Navy war surgery, expansion of the program of graduate training in surgery and surgical specialties by the American College of Surgeons, problems confronting the United States Veterans' Administration, emergency medical service in wartime disasters and medical service in industry. A 6:15 dinner will be followed by a general forum.

HASSIG ELECTED PRESIDENT

Dr. J. F. Hassig of Kansas City was elected president of State Medical Boards of the United States at the annual meeting of that organization held in Chicago on February 15, 1944.

Dr. Hassig is secretary of the Kansas State Board of Medical Registration and Examination and at one time was president of that board. He has held many offices in the Kansas Medical Society, and was its president in 1934 and 1935.

BLOOD PLASMA ARTICLE

The medical writer Paul de Kruif has again incited our ire with the recently published article condense from the Survey Graphic and published in the March issue of Readers Digest entitled "Michigan Leads the Way in Providing Blood Plasma for Everybody." The first paragraph of the article states: "Last year a workman, hurt in an automobile accident in Michigan was brought to a hospial His condition called for the prompt use of blood plasma, but the hospital followed the usual routine and first asked him who would guarantee its cost. He named the mayor and a banker in his home own. These men were not immediately available by phone—and meanwhile the man went into shock and died."

We do not believe that an accident victim in desperate need of blood plasma or transfusion would be questioned about his ability to pay by either the physician or the hospital. Most doctors of medicine and we believe most hospitals have carried or are carrying on their books at the present time, bills for like services which will never be paid but few if any of them will ask for or expect a guarantee when the individual's life is at stake. This is the sort of scare-head sentence that attracts the eyes of the reading public, and that all too often sells such articles to the press, and only proves the more our theory that the public is most eager for authentic health information, and it is too bad it can't always be authentic.

ACTION BY BAR ASSOCIATION ON WAGNER BILL

The recent action taken by the American Bar Association on the Wagner-Murray-Dingell bill is of great interest to our members. At the meeting of the American Bar Association which was held in Chicago in the summer a special committee was appointed to study the bill in full and the report of that committee was adopted by the House of Delegates of the American Bar Association on February 28, 1944.

The action taken was as follows:

"Resolved, that the Board of Governors be requested to appoint immediately a special committee to study, analyze and investigate Senate bill 1161, and that the Board of Governors give publicity to the recommendations and findings of such special committee and the action of the Board of Governors...that the House of Delegates is opposed to any legislation, decree or mandate that subjects the practice of medicine to federal control and regulation beyond that presently imposed under the American system of free enterprise...

"While your committee is concerned only with title IX, having to do with federal medical, hospitalization and related benefits, it has been found necessary to give some study to title IX-A—Federal Social Insurance Contributions, in order to estimate the amount of tax money and the number of individuals involved in the proposed socialized medical system.

"It is impossible for the general public to secure an accurate idea of the Socialized Medicine bill. Being a part of an extensive piece of proposed legislation, on other parts of which it is dependent, and prepare in a form which has become popular in the past ten years, being replete with involvement, cross references, new terminology, percentages and other confusing matters, the socialized medicine chapter leaves the reader in utter confusion as to its meaning or extent. As an example of the verbiage that causes such confusion we cite the following: The bill appears to entitle every individual who is currently insured and has been found by the board to be eligible for benefits under title IX in a current benefit year to receive general medical, special medical, laboratory and hospitalization benefits after the effective date of the title."

"SENATOR WAGNER'S INTERPRETATION OF THE BILL "When Senator Wagner (and Senator Murray) introduced S. 1161 on June 3, 1943, Senator Wagner made the following statement with reference to title IX:

"'Freedom of Medical Practice: There is no plan here, such as that lately considered in Britain, for a system of socialized medicine, with all doctors required to be salaried employees of the government. Unlike this British proposal, my bill assures complete freedom of choice of doctor and hospital by the patient, and freedom of medical practice and types of remuneration for the doctor and the hospital. No doctor is forced into the insurance system or forced on a salary status. Arrangements for obtaining medical, laboratory or hospital care would be essentially as they are now in this country, except that payment for the care and services would be out of the insurance fund, built up through the insurance premiums paid by the individual and his employer. Voluntary hospitals would, of course, be eligible to participate in the plan if they choose to do so and thus be enabled to expand their splendid community services. Nonprofit group medical or hospitalization plans may also be utilized in carrying out the program, and they would be in a position to offer supplementary health protection for families desiring more than the basic social insurance benefits guaranteed under the bill. In all its provisions this bill would promote the personal relations between doctor and patient and be adapted to the needs and practices of the individual community, and the wishes of the doctors in that community, in both rural and urban areas. Similar basic principles as to medical and hospital benefits and freedom of medical practices are embodied in a program recently put forward by the government of Canada, with the full accord of the Canadian Medical Association and the Canadian Hospital Council.'20"

"Senator Wagner's Statement Not Accurate.—Of course Senator Wagner does not have the time to engage in the exhaustive studies necessary to enable him to discuss fully the effect of socialized medicine in this country and throughout the world. He must of necessity depend on his staff to provide these studies for him. He doubtless depends also on others who are active in promoting the measure. Those who have assisted the Senator are not entirely accurate in some of their statements, and their conclusions in some instances are entirely incorrect.

"We point out the following inaccuracies in Senator Wagner's statement of June 3, 1943:

1. Senator Wagner states: S. 1161 is unlike the British proposal, which is the Beveridge plan with all doctors required to be salaried officers of the government.

The statement is misleading. Both plans look toward a system of medicine supervised, regulated and controlled by government. Under S. 1161 all doctors will be paid by the government, for in time there will be no private practice.

2. Senator Wagner states: There is complete freedom of choice of doctor by patient.

This is incorrect. If either the patient or the doctor named on the panel by the Surgeon General declines to accept the other, the patient is assigned to some other doctor.

3. Senator Wagner states: There is complete freedom of choice of hospital by patient.

This statement is incorrect. There is no provision for freedom of choice of hospital. The entire system is under regulation by the Surgeon General.

4. Senator Wagner states: There is freedom of medical practice for the doctor.

This is misleading. The plan is so extensive that in time there will be no private practice.

5. Senator Wagner states: There is freedom of types of remuneration for the doctor.

This is misleading. The doctor is forced on a salary or on a fee basis or on a combination of the two, as determined by the Surgeon General, who approves the fee tables.

6. Senator Wagner states: There is freedom of types of remuneration for the hospital.

This is incorrect. Hospital rates are determined by the Surgeon General with the approval of the Social Security Board.

7. Senator Wagner states: No doctor is forced into the insurance system.

This is misleading. He must go into the insurance system or be forced economically to cease the practice of medicine.

8. Senator Wagner states: No doctor is forced on a salary basis.

This is misleading. The doctor is forced on a salary or on a fee basis, or on a combination of the two, as determined by the Surgeon General.

9. Senator Wagner states: Arrangements for obtaining medical, laboratory or hospital care would be essentially as they are now in this country, except as to payment out of the insurance fund.

This is entirely incorrect. The whole medical system is supervised, regulated and controlled by government.

10. Senator Wagner states: Voluntary hospitals are eligible to participate in the plan.

This is misleading. They may participate if selected by the Surgeon General.

11. Senator Wagner states: The system would promote the personal relations between doctor and patient.

^{20.} Congressional Record 89:5344.

[&]quot;21. Inquiry from reliable sources in Washington indicates the probability that the actual designers and authors of S. 1161 are Isidore S. Falk and Wilbur J. Cohen, director and assistant director, respectively, of the Bureau of Resarch and Statistics of the Social Security Board, and Philip Levy, secretary to Senator Wagner.

This is an expression of opinion. The experience of foreign countries shows an opposite result.

12. Senator Wagner states: The Canadian system recently proposed is similar to S. 1611 and has the support of the Canadian Medical Association and the Canadian Hospital Council.

This is incorrect and misleading. The Canadian plan provides for its adoption by the provinces (or states) with a local full time doctor in charge. Both the Canadian Association and the Canadian Council are sharply critical of the plan.

"Let us analyze Senator Wagner's statement further:

(1) The British Medical Association, which is comparable to the House of Delegates of the American Medical Association, at its meeting on Sept. 21-23, 1943, considered the Beveridge plan, although there was no definite legislative proposal available for consideration. No doubt Senator Wagner had this plan in mind in making his statement of June 3, 1943. The Beveridge plan contemplates a complete system of state medicine, with salaried physicians, involving the entire abolition of private medical practice. The report of the plan provides that the administration shall be confided to local governments with the minister of health in general supervision.

The action of the association was limited to statements of principles and general positions. By a vote of 200 to 10 the resolution was adopted opposing the creation of a whole time salaried state medical service as not being in the best interest of the community.

The Representative Committee, which had been appointed to study the report, submitted an extensive report stressing, among other things, the necessity of free choice as between doctor and patient; that the loyalty and obligation of a doctor should be to the individual patient and to none other; that it was not in the public interest that the state should convert the medical profession into a salaried branch of central or local government service; and that the state should not assume control of doctors rendering individual or personal health service.²²

It would therefore appear that the Beveridge plan retains elements of local control which do not exist in Senator Wagner's bill.

(2,3) There is no 'freedom of choice' of doctor by patient, as we know that term today. The statute permits every individual to select those from whom he shall receive services, but his selection must be confined to one or more physicians furnishing such services under the direction of the Surgeon General [S. 1161, sec. 905(1)(2), p. 44]. The patient may change his selection, but only according to rules and regulations prescribed by the Surgeon General [ibid. sec. 905(2), p. 44].

If a practitioner selected by any individual refuses to serve the latter, the individual may, with others, be 'distributed' by the Surgeon General on a pro rata basis among the other practitioners [ibid. sec. 905 (11), p. 47]. There is no provision for freedom of choice of hospital.

(4, 7, 8) It is true that under S. 1161 all doctors are not required to be salaried employees of the government. Doctors employed under the scheme may be paid fees, or both salary and fees, as the Surgeon General directs. 'All' doctors may not be a part of the system, but the coverage is so great that little if any practice is left for the doctor who does not wish to become a part of the system.

(5) There is no freedom of remuneration for the doctor. The Surgeon General has full authority to approve pay-

22. J. A. M. A. 123:777 (Nov. 20) 1943.

ments to practitioners according to a schedule of fees, or on a per capita basis, or on a salary basis for whole or part time, or a combination or modification of all these. The statute [ibid. sec. 905(7), p. 46] on its face appears to give the practitioner some freedom, but the ultimate authority is in the Surgeon General, as all payments are 'subject to such necessary rules and regulations as may be prescribed' by the Surgeon General.

(6) Nor has the hospital any freedom with respect to remuneration. The Surgeon General [ibid. sec. 907(a), p. 49] with the approval of the Social Security Board determines the amount to be paid for hospitalization, varying from \$1.50 to \$6.00 per diem [ibid. sec. 915(g), p. 57].

(10) Voluntary hospitals are eligible, but subject to all the rules and regulations governing participating hospitals [ibid. sec. 907(a), p. 49; sec. 915(f)(g), pp. 56-57].

(11) Under our system of government and American way of life a plan of medicine directed from Washington would not 'promote the personal relations between doctor and patient, and be adapted to the needs and practices of the individual community, and the wishes of the doctors in that community, in both rural and urban areas,...' It is inevitable that such a plan would seriously disturb the existing intimate relationship between doctor and patient.

(12) Is it not correct that similar basic principles as to medical and hospital benefits and freedom of medical practices are embodied in a program recently put forward by the government of Canada, with the full accord of the Canadian Medical Association and the Canadian Hospital Council. The Dominion of Canada recognizes and respects its constitutional limitations. S. 1161 is utterly beyond the powers of Congress.

"For Senator Wagner to compare his bill favorably with the proposed Canadian measure is not justified. The Canadian plan provides for the adoption by each province of a model bill which the Dominion has drafted for the guidance of the provinces in framing their legislation. The Canadian government has no constitutional power to impose such a plan. It only proposes the plan and extends a subsidy to the provinces which adopt it. The question arises among the provinces whether or not the Dominion by this indirect procedure is not interfering with the autonomy of the provinces, by encroaching on the right given them under the British-North America Act to legislate as they see fit on matters of health.

"Another fundamental difference between S. 1161 and the Canadian plan is in its administration. Under S. 1161 the entire plan is administered by one man from Washington. In each Canadian province the act would be administered by a commission appointed by the Lieutenant-Governor-in-Council. Its chairman must be a doctor of medicine. He would be its chief executive officer and would have supervision over all other officers appointed to carry out the work of the commission. His fellow members on the commission would be men or women representative of the various professions rendering service under the act, including hospitals, and of industrial workers, employers, agriculturists and such other groups as it may be deemed desirable to recognize. The chairman would devote his whole time to the work of the commission and would be its only salaried member. Other members would be paid a per diem allowance for attending meetings. All persons employed to conduct the work of the commission would rate as civil servants and must be appointed in the manner prescribed by the Civil Service Act.

Thus the system in the provinces is removed from over-

all control from the seat of government and there remains to it all the elements of home rule.

"The insured may select from the list of practitioners who have agreed to attend insured patients anyone he wants as his medical adviser, subject only to the willingness of the latter to accept him as a patient. The total cost per annum would be \$250,000,000.²³ This figure is to be compared with approximately \$3,000,000,000 in this country.

"MEDICAL SERVICE IN THE UNITED STATES AND THE EFFECTS OF THE MEASURE ON SUCH SERVICE

- Under the medical care now provided in the United States the highest level of health and the lowest death rate ever known under similar conditions are being maintained.
- 2. There are being developed in this country and under our system of free enterprise many plans for providing adequate medical care without paying the price of socialized medicine. These include group and hospital insurance and Blue Cross plans under principles approved by the medical profession. The Blue Cross plan beginning in 1933 and now covering more than fifteen million people provides for the moderate means class, on which hospital bills fall heavily.
- 3. The indigent, who are most in need of free medical care, are not covered by S. 1161.
- 4. Forty-two per cent of the expenditures for hospital services and for doctors' services rendered hospital patients in 1942 were either tax supported or otherwise without cost to the patient and without recourse to federal regulation and control as proposed.
- 5. Of all like plans now in effect in foreign countries, none is comparable with the plan proposed by S. 1161 except the Russian system, which involves the complete socialization and regimentation of medicine. Such a pattern, if followed in this country, will inevitably produce a like result. The physician will become merely an unambitious federal employee or a politically ambitious doctor.
- 6. Contrary to assertions of the advocates of the measure, the plan covers practically the entire population of the United States except the indigent.
- 7. To safeguard a minimal percentage of the population which has difficulty in obtaining complete medical service, the bill would put all the people in a medical straight jacket under the supervision of the federal government for an alleged service which the vast majority either do not require or are able to provide for themselves.
- 8. The measure will inevitably lessen the interest of the physician in his patient as an individual and dull the incentive to produce the best results. The patient will become the guinea pig supplied by the government as the excuse for the payment of subsidies to a controlled profession for its routine services. This would disturb the social order of which both are members and result in vital loss both to the community and to the doctor.
- 9. The measure will subject to bureaucratic control and supervision the intimate and confidential relationship between doctor and patient and make confidential information resulting therefrom available to employees of the government.
- 10. Medical education and training, which have attained an unequaled standard of excellence in institutions conducted under our system of free enterprise, would under S. 1161 be subsidized, regulated and controlled by government.
- 11. Within the past twenty years the center of medical progress has moved from Germany, Austria and England,

23. Health Insurance for Canada, Research Bureau Pharmaceutical Manufacturers' Association, Toronto, pp. 3, 4, 8, 9, 10, 19.

which have adopted some form of state medicine and which previously served as centers of postgraduate medical education, to the United States, and we now find physicians and hospital administrators coming for guidance and inspiration to this country, where no form of state medicine is in effect.

CONCLUSION

"The American Bar Association is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. Under normal circumstances, therefore, it is not the function of this association to attempt to influence substantive legislation by the Congress of the United States. But when under the pretext of the general welfare legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country, it becomes the duty of this association actively to voice its objections, a summary of which is as follows:

- 1. Local self government must be preserved in our federal system. State governments directly responsible to the will of the people are best adapted to exercise such supervisory control as may be instituted over the health and medical care of our citizens.
- 2. S. 1161 seeks to invest in the Surgeon General, who is not an elected servant of the people and who is not amenable to their will, the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home.
- 3. The measure furnishes the instrumentality by which physicians for their practice, hospitals for their continued existence and citizens for their health and that of their families can be made to serve the purposes of a federal agency.
- 4. The bill fails to safeguard the rights of patients, citizens, hospitals or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.
- 5. The bill fails to provide for any appeal to any court from the action of the Surgeon General.
- 6. The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government and incompatible with the adequate protection of the liberties of the people.

"The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear on them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates.

Respectfully submitted,

W. E. STANLEY, Chairman, WILLIAM LOGAN MARTIN, CLEMENT F. ROBINSON, Subcommittee."

Feb. 25, 1944.

★ BUY AN EXTRA BOND

NEW DOCTORS OF MEDICINE

The Kansas State Board of Medical Registration and Examination held a special examination in Kansas City, Kansas on February 2 and 3, 1944, for the convenience of the graduating class of the School of Medicine of the University of Kansas. The board wishes to announce that certificates to practice medicine and surgery in Kansas were granted to the following named ninety-two doctors: Don R. Abbuehl, Atchison

William F. Anderson, Chanute

Daniel B. Arst, Wichita

Pat A. Barelli, Kansas City, Missouri

Harvey L. Barry, Columbus

Edgar H. Beahm, Bison

Evert C. Beaty, Parsons

John P. Berger, Wichita

James F. Bigalow, Baileyville

Grover C. Black, Topeka

William F. Blair, Kansas City

Fred N. Bosilevac, Kansas City

Robert O. Brown, Iola

Ivan W. Cain, Dodge City

Charles A. Campbell, Downs

Milford B. Campbell, Salina

Roswell E. Capsey, Frankfort

George C. Chaney, Independence

Stanley J. Christian, Kansas City

Norman L. Claybourn, Fort Scott John B. Coleman, Atchison

Thomas W. Critchfield, Effingham

Frederick G. Dietrich, Broughton

Francis L. Edwards, Wichita

Edward H. Fischer, Ellinwood

W. David Francisco, Kansas City

Florian G. Freeman, Colby

Carl M. Friesen, Hillsboro

Oliver M. Gilliland, Kansas City, Missouri

Richard Gunn, Kansas City

Robert F. Hagen, Atchison

John M. Haight, Paola

Robert F. Harp, Mankato

Claib B. Harris, Garnett

John J. Hill, Pleasanton

Richard H. Hill, Humboldt

John G. Hoffer, Jr., Wichita

William W. Holmes, Stanley

James H. Holt, Wichita

Morton Jacobs, Kansas City, Missouri

Craig S. Jones, Baldwin

Edward S. Jones, Canton

Robert A. Jordan, Baldwin

George B. Joyce, Topeka

Irving Kass, Topeka

Robert M .Knox, Westmoreland

James G. Lee, Jr., Bonner Springs Jack Maxwell Leopard, Kansas City

Robert S. Lockwood, Streator, Illinois

Harold L. Low, Wichita

James N. Lysaught, Kansas City

John N. McAllister, La Crosse

Arthur A. McAuley, Wichita

James E. McCormick, Plainville

Gaylord E. Manahan, Wellington

Howard E. Marchbanks, Pittsburg

Frank J. Martin, Garden Plain

Jack Newton Martin, Lawrence

John N. Martin, Kansas City, Kansas

Paul W. Meyer, Kansas City Elden V. Miller, Salina Floyd E. Muck, Clay Cenetr Franklin L. Murphy, Anthony Noel L. Neifert, Kansas City George M. Osgood, White Cloud

William O. Martin, Sterling

Earl G. Padfield, Jr., Salina Charles C. Parmley, Hutchinson

Charles R. Phelps, Fort Scott

John B. Pierron, Kansas City, Missouri

William W. Pierson, Oakley Lowell A. Postma, Kansas City

Robert G. Powell, Galena

Ralph R. Preston, Topeka

Frank J. Price, Topeka

William C. Rasmussen, Morganville

Hugo A. Sacchet, Topeka

Sydney O. Schroeder, Wichita

William B. Scimeca, Caney

Henry A. Shields, Philadelphia, Pennsylvania

Jay L. Sitterley, Great Bend

William A. Slentz, Wichita

Francis M. Spencer, Topeka

Stanford D. Splitter, Frederick Charles E. Stevenson, Parsons

William A. Tanner, Aurora, Illinois

Isami Tashima, Puna, Hawaii

Gerhard R. Tonn, Haven

Robert E. Trekell, Wellington

James T. VanBiber, Andover

Roger P. Weltmer, Beloit

Otis G. Zacharis, Topeka

The next meeting of the Board will be held in Topeka at the Kansan Hotel on June 8, 1944, at 10:00 a. m., for the transaction of business only. The next examination will be held during the first week in November. The exact date will be announced at the June meeting.

DR. NEFF TO AMERICAN CANCER SOCIETY

J. Louis Neff, executive secretary of the Nassau Medical News, of Mineola, New York, has resigned that position to become executive director of the American Society for Control of Cancer.

CIVILIAN DEFENSE CHIEF RESIGNS

The office of Civilian Defense in Washington, D. C., announced on February 24, 1944, the retirement of Dr. George Baehr on March 1, after two and a half years of service. Dr. Bahr will be succeeded by Dr. W. Palmer Dearing, who has been assistant chief medical officer since the establishment of the medical division of the office of Civilian Defense.

The medical division of the office of Civilian Defense was established prior to the attack on Pearl Harbor, for the protection of the civil population of the country and its outlying territorial and insular possessions against the hazards of enemy attack and other wartime disasters.

The division, under Dr. Baehr's leadership, has established regional medical and sanitary engineering officers, emergency medical service in every state and local community throughout the country, organized agencies for the protection against war gases, trained groups in the techniques of rescue work, established a nationwide system of casualty receiving hospitals, organized emergency base hospitals in twenty coastal states, and 180 hospital blood and plasma banks, set up reserve depots of dried and frozen plasma in 400 cities, organized more than 120 affiliated hospital units (each consisting of 15 physicians, surgeons and specialists commissioned in the reserve of the United States Public Health Service) and eighty emergency nursing units (each comprised of twenty-two nurses), and trained 150,000 volunteer Nurses' Aids under the Red Cross for war time volunteer service in hospitals.

CAHAL TO SOUTHWESTERN MEDICAL FOUNDATION

Mac F. Cahal, formerly the secretary of the Sedgwick County Medical Society and more recently the executive secretary of the American College of Radiology in Chicago, has been appointed executive officer of the Southwestern Medical Foundation in Dallas, Texas.

Mac Cahal will be remembered by all Sedgwick County members and many throughout the state. We congratulate him on his new job and wish him the best of luck.

RADIO PROGRAM

The radio broadcast sponsored by the American Medical Association, the National Broadcasting Company and the Medical Department of the United States Army and Navy entitled "Doctors At War" will be on the air each Saturday afternoon (3:30 Central war time and 4:30 p. m. Eastern war time).

PHYSICIANS SUBJECT TO EMPLOYMENT STABILIZATION PROGRAM

The War Manpower Commission has recently announced that physicians, dentists, veterinarians, sanitary engineers and nurses who are salaried employees in essential or locally needed activities are hereafter subject to the same provisions of any employment stabilization program as applies to other workers in such activities. Such professional employees may not change their jobs without securing statements of availability from the United States Employment Service or being referred to new jobs by this service. The Employment Service, however, will make referrals of such employees only after consulting the state chairman of hte Procurement and Assignment Service. On approval of the regional war manpower director, any state director may delegate the duty of referring such employees to new jobs to the state and local offices of the Procurement and Assignment Service.

COUNTY SOCIETIES

The Clay County Medical Society held a dinner meeting in Clay Center on February 9. Dr. R. R. Cave of Manhattan, councilor for the Seventh District spoke on "The Postgraduate Plan for Kansas and the Prepayment Medical Service Plan." Dr. F. L. Loveland of Topeka discussed "Our War Effort." The new county contract for Clay County was discussed by the membership.

The Cowley County Medical Society at its meeting in Winfield on February 17 had Lt. Chambers of the army public health service as the guest speaker. The next regular meeting of the society will be held in Arkansas City on March 16.

The Johnson County Medical Society held a dinner meeting in Olathe on February 7. Dr. Herbert L. Mantz of Kansas City, Missouri, spoke on "Tuberculosis."

The Marion County Medical Society held a meeting in Marion on February 2 with the members of the Harvey County Medical Society and the McPherson County Medical Society as guests. Capt. J. A. Whallun of the Herington Air Base spoke on "Venereal Disease Problems of the Army and Control Methods" and Major Woodward, Provost Marshall of the same post gave an interesting talk on "Juvenile Delinquency."

The Montgomery County Medical Society held a meeting in Coffeyville on February 18. Dr. H. L. Hiebert, director of the Division of Tuberculosis Control of the Kansas State Board of Health and Dr. C. H. Benage, of Pittsburg, councilor for the Third District were the guest speakers.

The Wilson County Medical Society and the Auxiliary to the Wilson County Society entertained with a dinner in Fredonia on February 9. Dr. C. H. Benage of Pittsburg was the guest speaker.

DEATH NOTICE

Dr. Clarence Benjamin Francisco, 64 years of age, died on February 23 in Kansas City. He was born in Unionville, Missouri, in 1880 and was graduated from the University of Kansas School of Medicine in 1907 and in 1914 completed post graduate work in orthopedics in European clinics. During World War I he was consulting orthopedic surgeon for the American Expeditionary Forces in France and Scotland with the rank of lieutenant colonel. At the time of his death he was clinical professor of orthopedic surgery at the University of Kansas School of Medicine and held a reserve colonel's commission in the Army Medical Corps. He was a member of the Johnson County Medical Society.

Dr. Joseph D. Horton, 77 years of age, died on February 14 at his home in Plevna. He was graduated from the Hospital College of Medicine of Louisville in 1893 and was an honorary member of the Reno County Medical Society.

Dr. Frederick W. Jones, 72 years of age, died on February 21 at his home in Girard. He was born in Pinckney, Illinois, on May 12, 1871, and was graduated from the Barnes Medical College in St. Louis, Missouri, in 1901 and first practiced in Earlton, Neosho County. He was a member of the Crawford County Medical Society.

MEMBERS

Dr. Joseph Richard Adams formerly of Udal has moved to El Dorado.

The article on Migrane by Dr. F. A. Carmichael which was printed in the October, 1943, issue of the Journal was

Healers on the heights

Crawling the crags at dawn . . . Exposed on rocky ledges in the blistering noonday sun . . . Fighting pain and death through the freezing night . . . Unarmed and unafraid, the medical officer on mountain duty is often marooned amid harrowing hardships for days on end, unrelieved except for an occasional cigarette . . . a cheering Camel most likely . . . the soldier's favorite smoke.

Camel is first choice of the armed forces* because Camel rates first for mildness, first for fine flavor. Remember that—when you send cigarettes to friends and relatives in service. Send Camels—the brand that's sure to please.

Ist in the service

*With men in the Army, the Navy, the Marine Corps, and the Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)

Camel costler tobaccos

New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y. abstracted in the January, 1944, issue of Current Medical Digest.

Dr. D. Carr of Topeka, in charge of the city-county health department, was appointed a member of the sub-committee on medical care of the American Public Health Association at its annual meeting in New York on February 11, 1944.

Dr. H. R. Goshorn, formerly of Arcadia and more recently of Lamar, Missouri, has located in Alton where he has opened offices.

Dr. O. J. Hartig of Downs and more recently of Kansas City is in the Hillcrest Hospital at Pocatello, Idaho.

Dr. R. M. Heilman of the Kansas State Board of Health attended the War conference of the Industrial Health Council of the American Medical Association held in Chicago on February 13-18.

Dr. C. Alexander Hellwig of Wichita is the author of an article entitled "The Goiter Heart; An Experimental Study" in the January, 1944, issue of Archives of Surgery.

Dr. John Hewett of Wakefield is with the Douglas Aircraft Corporation at Daggett, California.

"The Psychoneuroses of War" by Dr. Robert Knight of Topeka was condensed in the Current Medical Digest for December, 1943, from the Bulletin of the Menninger Clinic.

Dr. David Loy has moved from Kansas City to Great Bend where he practiced sometime ago.

Dr. Fred Mayes, formerly the director of the Division of Maternal and Child Health of the Kansas State Board of Health, now Regional Medical Consultant of the United States Children's Bureau, is stationed in Atlanta, Georgia.

Dr. J. D. Pettet of the Jayhawk Ordnance Works at Pittsburg has recently resigned to accept a position with the North American bomber plant in Kansas City.

Dr. H. C. Ulery of De Sota has moved to Parsons where he is with the Parsons Ordnance Plant.

MINUTES

The following are the minutes of the meeting of the Council which was held in Topeka on January 9, 1944:

"The Council met in Topeka on January 9th and attended to many matters of importance. Dr. Harold H. Jones of Winfield presented a plan for post-graduate study with special emphasis placed upon the importance of offering suitable work for our men returning from the service, also a plan whereby members of our profession can take post-graduate work at our University at any time. He and his committee will present definite and final plans at the meeting of the House of Delegates in May. It is proposed to raise a fund for this purpose from among our members, and donations have already started, but more details will come later.

'The annual meeting will be held in Topeka on May



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10 and 11, a two-day meeting, House of Delegates on Wednesday morning, program that afternoon, night and Thursday until 4 o'clock, then the second meeting of the House of Delegates.

"Mr. Robert A. Brooks, Executive Secretary of the Society, has resigned. A committee, composed of Drs. Tihen, Trueheart, Callahan, Hassig, Mills, Croson, Loveland and myself were appointed to select a successor. Mrs. Margaret Foster was elected to act as temporary secretary.

"Dr. B. A. Nelson of Manhattan, chaîrman of the Medical Economics Committee, presented a plan, to be operated by the Society, for an insurance program covering surgery, orthopedics and obstetrics. The report was very complete, showing successful operation of these programs in various states. He was instructed to make a final report to the House of Delegates in May.

"Dr. Grove of Newton displayed a full page ad, with cartoons, which their county society had sponsored, portraying the bad features of socialized medicine. These cartoons are furnished by the National Physicians Committee and it is suggested that county societies send to that organization for various cartoons and literature which can be used in local newspapers. I think it unwise to ask the local newspapers to carry these advertisements free of charge. It would seem that we would do well to spend some money with them in wise advertisement; it will return big dividends in friendship.

"The American Medical Association has directed a letter to me asking that I request each county society to appoint a Public Information Committee from their own group. Information of interest to the public will be sent out from our Public Policy Committee from time to time and it would be wise to have a committee in each society to handle this detail. Will you please send the name of the chairman of your committee to the central office.

"Dr. Frank Foncannon of Emporia was elected to the Council to succeed Dr. Phil Mogan, now in the service.

It is extremely important that each county society and each physician in the state take an active interest at this time in the men announcing their candidacy for the legislature. I cannot urge you too strongly to attend to this matter at once. I feel very positive that if the physicians in Kansas will pay proper attention to the candidates for the legislature before they are elected, we can have representation that is at least favorable to our profession.

"We in the central office will do our best to carry on. May I ask that you cooperate with us in seeing that our membership is kept up at this time."—J. L. Lattimore, M.D., President.

MEDICAL JOURNALS IN WAR TIME

The problems that confront the publishers of medical journals in countries at war appear frequently in editorials, announcements and in news notes. This shortage of worth while scientific material seems to be universal and one of the major problems. This has been brought about by the cancellation of scientific sessions, the fewer number of county meetings with scientific speakers, the increase in work and the time element, and the great number of men in service, few of whom have time for scientific writing. Labor shortage in printing plants and in the journal offices is evident in many journal notes. All journals have been reduced in size due to government request and paper shortage. Thanks to the faithful advertisers this is not one of the present war problems. We extend sympathy to the Illinois Medical Journal who had an original problem in



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43 Illus. 412 Pages. \$5.50 (1943)

Practice of Refraction, 4th Edition

By Sir Stewart Duke-Elder (London)

This book presents all that is necessary for the clinical practice of refraction without burdening the reader with innumerable mathematical proofs.

183 Illus. 328 Pages \$4.50 (1943)

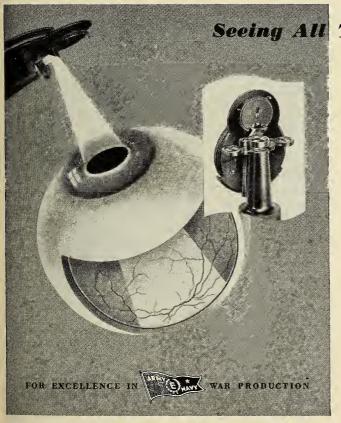
Hughes' Practice of Medicine, 16th Edition

Revised and Edited by Burgess Gordon, Jefferson Medical College

This book presents a convenient grouping of essential facts under each disease giving the latest information. Articles on the sulphonamide drugs, modern war gases and latest methods of treatment are included.

36 Illus. 791 Pages. \$5.75 (1942)

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the January issue of their Journal. Editorially they announced in February: "Did you get your January Journal? If not—here is the reason. The truck taking the complete issue from the printer to the post office caught fire. A few of the mail bags with their contents were badly burned.... Additional Journals were printed and mailed later."

It is interesting to find that half-way across the world the other medical publications are having their difficulties too and the Journal of the Indian Medical Association printed in Calcultta has this to say: "If you are feeling the shortage of quinine, sulphanilamide derivatives and meeting various spurious ineffective drugs, it is due to war. Of the shortage of rubber and petrol? We are afraid for the former, you will have to wait until Malay is reconquered. Of the latter we refer you to the interesting discussion at Patna during the 19th Conference... Have not you felt that we started slimming from the year Japan has rushed into the war? This is not intentional but essential. As a human body gradually reduces due to food shortage, we slimmed due to paper shortage.... At one time during the year of Grace 1943, we were threatened with complete annihilation (to use the war jargon) by the commandeering order of 90 per cent output of India's paper and the Blackmarketwallahs. We were somehow or other resuscitated by a windfall. But we are not steady yet. Haven't you noticed that our paper lacks the milky white freshness? Though gas warfare is still in the air, chlorine can not be spared for bleaching paper.... Even the mail is not regular during this warfare. Priority claims have not yet been the

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fashion in post offices, otherwise we would have applied for it. If you had known how many times galley proofs, page proofs, etc., are batted between us, press and sometimes the contributor, you would have appreciated why there is still a little delay in the appearance of the Journal and the importance of regular mail. How can we explain the fact, except due to war exigencies, that our members are so quickly changing places in a way so as to leave our circulation department dizzy. We are sure the Journal will catch them in the end."

But the editorial desk experiences a shock from the cover page of the December issue of the Southwestern Medicine. In red letters were the words "Last Issue Until Victory." An editorial written by Dr. M. H. Spearman of El Paso, Texas, in his farewell editorial reviews the history of the Journal which has represented the Arizona State Medical Association, the New Mexico Medical Society, the Southwestern Medical Association and the El Paso County Medical Society. In the next batch of Journals, however, we find volume 1, number 1 of the Arizona Medicine dated January-February, 1944. So the Arizona Medical Association is determined to let the war make no difference and is now publishing their own Journal at Phoenix, Arizona. Congratulations and "Bravo." It's a fine new publication and one to be proud of in these war times.

The Virginia Medical Journal comes out on January with a new and most attractive cover design in white with the "Virginia" done in handlettering and printed in blue. The border design incorporates the staff of Aseculpius in the lower right hand corner.

The Rhode Island Medical Journal has pioneered in the field of medical journals in its January issue with a

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The Treasury Department acknowledges with appreciation the publication of this message by

The Kansas Medical Society

dental section. An editorial entitled "Physicians and Dentists," has this to say: "With this issue a dental section is added, and the Journal thereby becomes the official publication also of the Rhode Island State Dental Society. This action, approved by the Publication Committee of the Journal, marks the first instance, to our knowledge, in the country where a state medical journal has also extended its service to the closely allied profession of dentistry.... Among the major weaknesses reported of dentistry in New England is the absence of a publication issued frequently enough to have any timely value. If the medical journal may now in some measure remedy that situation for the dentists of Rhode Island, and if through the medium of its columns it may strengthen the medical and dental organizations for combined action for the support of better health for all the citizens of the state, it will have made a significant contribution to the professions it now serves."

burgh, Pennsylvania on June 7 through June 13, 1944. Candidates for reexamination in Part II must have written application in the Secretary's office not later than April 15, 1944. The Office of the Surgeon General of the United States Army has issued instructions that men in service, eligible for board examinations, be encouraged to apply and that they may request orders to Detached Duty for the purpose of taking these examinations whenever possible. Applications are now being received for the 1945 examinations according to the secretary. Address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania, for additional information.

World's most expensive vitamine, biotin, which in its natural state costs \$4,000,000 an ounce, is now produced synthetically by a chemical concern in New Jersey. The company expects to find many new uses for this powerful vitamin.—Nebraska State Medical Journal.

Aristotle, the ancient Greek philosopher, advised over 2,000 years ago the eating of liver to prevent night blind-

ness.-Minnesota Medicine.

ANNOUNCEMENT

The American Board of Obstetrics and Gynecology announces that general oral and pathology examinations (Part II) for all candidates will be conducted at Pitts-

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BOOKS RECEIVED

PICTORIAL HANDBOOK OF FRACTURE TREAT-MENT—Edward L. Compere, M.D., F.A.C.S., Associate Professor of Surgery of Northwestern University Medical School; Chairman of the Department of Orthopaedic Surgery of Wesley Memorial Hospital; Consulting Orthopaedic Surgeon of Chicago Memorial Hospital and Sam W. Banks, M.D., Associate in Surgery of Northwestern University Medical School; Attending Orthopaedic Surgeon of Chicago Memorial Hospital. Published by the Year Book Publishers, Inc., of Chicago, Illinois.

ROENTGENOGRAPHIC TECHNIQUE, A Manual for Physicians, Students and Technicians — Darmon Artelle Rhinehart, A.M., M.D., F.A.A.R., professor of roentgenology and applied anatomy of the school of medicine, University of Arkansas; roentgenologist to St. Vincent's infirmary, the Missouri Pacific Hospital and the Arkansas Children's Hospital of Little Rock, Arkansas; trustee of the American registry of x-ray technicians. The third edition, thoroughly revised with 201 engravings is priced at \$5.50. Published by the Lea and Febiger Company of Philadelphia.

METHODS OF TREATMENT — Logan Clendenning, M.D., Clinical Professor of Medicine of the University of Kansas School of Medicine and Attending Physician of the University of Kansas Hospital, and Edward H. Hashinger, A.B., M.D., Clinical Professor of Medicine of the University of Kansas School of Medicine, Attending Physician of the

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CONVULSIVE SEIZURES, How to Deal with Them, A Manual for Patients, Their Families and Friends — Tracy Putnam, M.D., professor of Neurology and Neurosurgery of the College of Physicians and Surgeons of Columbia University, and Director of Service of Neurology and Neurosurgery of the Neurological Institute of New York. This book published by the J. B. Lippincott Company of Philadelphia, Pennsylvania, is priced at \$2.00.

THE YEAR BOOK OF GENERAL MEDICINE, 1943—Edited by George F. Dick, M.D., J. Burns Amberson,

Jr., M.D., George R. Minot, M.D., S.D., F.R.C.P. (Edinburg and London), William B. Castle, M.D., S.M., M.D. (Hon.) Utrecht, William D. Stroud, M.D., and George B. Eusterman, M.D. Published by the Year Book Publishers, Inc., of Chicago, Illinois and priced at \$3.00.

REHABILITATION OF THE WAR INJURED — A Symposium — Edited by William Brown Doherty, M.D and Dagobert D. Runes, Ph.D. Published by the Philosophical Library, Inc., 15 East 40th Street, New York, N. Y. This volume of 684 pages discussed neurology and psychiatry, reconstructive and plastic surgery, orthopedics, physiotherapy, occupational therapy and vocational guidance and the legal aspects of rehabilitation. It is priced at \$10.00.

THE MIND OF THE INJURED MAN — Joseph L. Fetterman, M.A., M.D., Assistant Clinical Professor of Nervous Diseases of the Western Reserve University School of Medicine of Cleveland, Ohio. Published by the Industrial Medicine Book Company of Chicago, Illinois, the book is priced at \$4.00.



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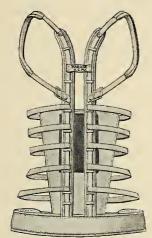
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KANSAS MEDICAL ASSISTANTS SOCIETY

STATE MEETING PLANS-The annual state convention of the Kansas Medical Assistant's Society will be held on Friday, May 12, at the Hotel Allis in Wichita. The committee in charge of the arrangements for the meeting was unable to secure accommodations for a Sunday meeting as has been scheduled previously. However, they feel that the meeting will be well worth the effort expended for those who can attend. Additional plans for the meeting will be published in the April issue of the Journal.—Mrs. Fave Bullard, Secretary.

The Sedgwick County Medical Assistant's Society held their monthly meeting and dinner at the Hatel Allis on February 16. Mrs. Samuel West of Wichita gave a book review on the "Burma Surgeon."

The Shawnee County Medical Assistants' Society entertained with a valentine party at the Hotel Kansan on February 14. Twenty-five members and guests attended. Miss Carolyn McClure gave a short graph-o-analysis of each girl's handwriting. Maxine Dreyer was program chairman for the party and was assisted by Myrna Sutton and Grace McMillan.

The death rate of war casualties in the American forces continues to be surprisingly low. Never before in the war history of our nation have our armed forces been so well taken care of, medically, as at the present time. And we do not overlook the fact that our nursing program is the best any nation has ever had, which materially adds to such an excellent mortality report.—The Journal of the Indiana State Medical Association.

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Solution of Estrogenic Substances, Smith-Dorsey, has won the confidence of many physicians in the performance of this delicate task. Coming from the capably staffed Smith-Dorsey laboratoriesequipped to the most modern specifications, geared to the output of a strictly standardized medicinal—it deserves their confidence—and

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ne case, observed for yourself, is more convincing than a hundred published case histories. Why not have your patients change to PHILIP MORRIS cigarettes, and watch the results! Your own observations will mean even more than the published studies, which showed that on changing to PHILIP Morris every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.*

* Laryngoscope, Feb. 1935, Vol XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

AUXILIARY

PRESIDENT'S MESSAGE

This has been a very difficult year in many ways, but the Auxiliaries have responded cheerfully to the many inconveniences and extra duties they have been asked to perform. It has been gratifying to me that some of our smaller organizations have been able to hold together when so few members were left. A few Auxiliaries have gained in membership so our state membership has not decreased as much as had been expected.

The coming month of April is the time when the Women's Field Army has asked for our help. Many will be assisting in this great cause, but many more should help than are doing so. The theme is "Time" and many pertinent slogans as "Treated in Time Cancer Can Be Cured, and "Learn the Danger Signals," will be used in the 1944 campaign. If you can not take enlistments at least you can be a contributor. Every doctor's wife should take an active part. We stress health education. This is a definite health education program.

It is time for every member to be thinking about the state Auxiliary meeting and getting their delegates and alternates elected. We are hoping for a large attendance. The Shawnee County Auxiliary, with Mrs. John L. Lattimore as general chairman, will have charge of the arrangements. The business meetings will be held in the Hotel Jayhawk. The program sounds almost like the "good old days." The Topeka women are being most generous and have planned many things for our entertainment. Please be there to enjoy it.

If the reports which were to have been sent in March 25 have not been mailed, they must be sent in immediately. The Handbook which each county president and state chairman holds gives definite instructions.

Sincerely,

Mrs. E. E. Tippin

STATE AUXILIARY MEETING

Mrs. J. L. Lattimore of Topeka, general chairman of the committee for the sate Auxiliary meeting, which will be held in Topeka at the Hotel Jayhawk on May 10 and 11, 1944, has announced the following committee chairmen: Committee in charge of tea arrangements, Mrs. W. M. Mills; luncheon committee, Mrs. Vernon Wiksten; courtesy and registration committee, Mrs. H. H. Woods; tour of Winter General Hospital will be under the supervision of Mrs. E. H. Decker and Mrs. P. M. Powell in charge of the program committee. Additional announcements and the completed program will be published in the April issue of the Journal.

AUXILIARY NEWS

The Women's Auxiliary to the Saline County Medical Society entertained with a dinner at the home of Mrs. E. M. Sutton in Salina on February 10. Mr. John Hunt, Red Cross field director of the Smoky Hill Army Air Field spoke on "Red Cross Service to the Armed Forces." The following new officers were elected: Mrs. C. D. Armstrong as president, Mrs. C. M. Fitzpatrick as vice-president and Mrs. E. J. Ryan as secretary-treasurer.

The Women's Auxiliary to the Shawnee County Medical Society held a dessert luncheon on March 13 at the home of Mrs. Leo Turgeon in Topeka. Mrs. Leo Smith and Mrs. Harry Bowen were the assisting hostesses. The program on "Flower Arrangements" was in charge of Mrs. R. E. Pfuetze.

The Women's Auxiliary to the Wilson County Medical Society held a meeting on February 9 in Fredonia and a joint dinner with the Wilson County Medical Society. Guests were Mrs. E. E. Tippin of Wichita, the state president of the Women's Auxiliary, Mrs. E. J. Nodurfth of Wichita and Mrs. C. H. Benage of Pittsburg.

The Women's Auxiliary to the Wyandotte County Medical Society held a meeting in Kansas City on March 10 at the home of Mrs. A. Huber. The officers of the Women's Auxiliary to the Jackson County Medical Society were the guests. Assisting hostesses were: Mrs. G. H. Hobson, the chairman, Mrs. E. L. Asbell, Mrs. R. A. Richeson, Mrs. A. C. Ryan, Mrs. Leland Speer, Mrs. J. W. Sparks, Mrs. James May, Jr., Mrs. L. L. Bressette, and Mrs. Fred Mills. Mrs. Donald Medearis reviewed the book "Dr. Wassell" by James Hilton and Mrs. E. R. Millis sang a group of songs accompanied by Mrs. L. B. Gloyne.

DOCTORS' HOUSEHOLDS URGED TO SET AN EXAMPLE IN WASTE FAT SALVAGE

The importance of saving waste household fats in order to salvage their glycerine content should be apparent to every physician. The doctor's kitchen, like that of every other family in town, can supply at least a tablespoonful of fat a day, from meat drippings, from rendered trimmings or fat skimmed from the soup kettle and no longer good for food. If that much were retrieved in every household and taken to the meat stores which collect the fat for the renderers, the amount saved would exceed the national goal

Glycerine is indispensible in the manufacture of munitions, because it is the source of both nitroglycerine and dynamite, the first of which provides the explosives for propellants and the second the means of military demolition. Tanks, ships and planes last longer because of paints containing glycerine. It is used as an anti-icing fluid for the propellors of fighter and bomber planes. The shock absorbers of jeeps and half-tracks, the recoil mechanisms of big guns and the firing mechanisms of depth bombs all contain glycerine.

Practically all the liquid sulfonamides call for glycerine. The war has given increased emphasis also to the long-established value of glycerine itself in burn therapy and surgical treatment, as well as for wound dressings. Dressings can be changed with less discomfort to the patient when they are soaked with glycerine.

The War Production Board is urging all Americans everywhere to help save that fat from which this precious liquid is made. The meat dealer from whom you purchase food will be glad to pay the prevailing rate for the kitchen fats your household conserves. The pennies will buy War Stamps, and every pound of waste cooking fats turned in will provide enough glycerine to make a half-pound of dynamite or four 37 mm. antiaircraft shells or their equivalents in other badly needed materials. Doctors, set an example in your community; start your household saving waste kitchen fat today!

THE JOURNAL of the KANSAS MEDICAL SOCIETY

Owned and Published by The Kansas Medical Society

Volume XLV

APRIL, 1944

Number 4

Greetings

The Shawnee County Medical Society is happy to welcome the doctors of medicine and their wives who will attend the 85th annual session of the Kansas Medical Society in Topeka on May 10 and 11.

The 1944 session has been shortened due to war conditions and many of the social activities of the meeting have been omitted. An excellent program has been prepared by Dr. Dwight Lawson and his committee. An examination of the speaker list and the program which is printed in this issue of the Journal will inform you of the outstanding group of men who have been secured to represent as many branches of medicine as is possible in the allotted time.

Our thanks are extended to the doctors who will participate and who no doubt have made sacrifices to be with us at that time.

We have been informed by the hotels that it will be necessary this year to make luncheon and banquet reservations previous to the meeting date and are sending from the central office return cards for you to fill out. We hope that you have already secured your hotel reservations. If not, may we advise you to do so at once.

To all who have shared in the responsibility of preparing for the meeting we wish to extend our gratitude and to you who will attend, we hope your visit will be pleasant and most profitable.

Sincerely,

Paul E. Belknap, M.D. President, Shawnee County Medical Society

Guest Speakers



O. THERON CLAGETT, M.D.

Rochester, Minnesota

GRADUATE—University of Colorado and University of Minnesota.

MEMBER—American College of Surgeons, American Board of Surgery, Trudeau Society. Head of the Section, Division of Surgery, Mayo Clinic, Rochester, Minnesota and Professor of Surgery of the Mayo Foundation.



JOHN S. COULTER, M.D.

Chicago, Illinois

GRADUATE—University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

MEMBER—American College of Surgeons. Associate Professor of Physical Therapy Northwestern University Medical School, Chicago, Illinois.

M. EDWARD DAVIS, M.D.

Chicago, Illinois

GRADUATE—University of Colorado, University of Chicago, Rush Medical School.

MEMBER—Chicago Gynecological Society, Central Association of Obstetrics and Gynecology, Fellow American College of Surgeons, Diplomate American Board of Obstetrics and Gynecology.

Professor of Obstetrics and Gynecology of the University of Chicago, Attending Obstetrician of Chicago Lying-in-Hospital.



WILLIAM G. GORDON, M.D.

Kansas City, Kansas

GRADUATE—University of Michigan Medical School, Ann Arbor, Michigan.

Associate Professor of Surgery (Urology) University of Kansas School of Medicine, Kansas City, Kansas.





ARCHIBALD L. HOYNE, M.D.

Chicago, Illinois

GRADUATE—University of Chicago, Rush Medical School.

MEMBER—American Academy of Pediatrics, Fellow American College of Physicians, Chicago Pediatric Society.

Clinical Professor of Pediatrics of Rush Medical School, Attending Physician Cook County Hospital, Chief of Contagious Disease Department.



EDWARD MASSIE, M.D.

St. Louis, Missouri

GRADUATE—Washington University School of Medicine, St. Louis, Missouri.

MEMBER—American Board of Internal Medicine, Central Society for Clinical Research, Associate American College of Physicians, American Heart Association.

Instructor in Clinical Medicine, Washington University School of Medicine, Director of Cardiac Clinic, Washington University Clinics.

A. D. RUEDEMANN, M.D.

Cleveland, Ohio

GRADUATE—University of Michigan Medical School, Ann Arbor, Michigan.

MEMBER—American Board of Ophthalmology, American Academy of Ophthalmology and Oto-Laryngology, American Ophthalmological Society.

Ophthalmologist, Cleveland Clinic Foundation Hospital.



HOWARD A. RUSK, Lt.Col., M.C. Washington, D. C.

GRADUATE—University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

MEMBER—American Board of Internal Medicine, American College of Physicians.

Lieutenant Colonel, Medical Corps, Chief of Convalescent Training Branch, Medical Service Division, Office Air Surgeon, Washington, D. C.





ROBERT D. SCHROCK, M.D.

Omaha, Nebraska

GRADUATE—Cornell University Medical College, New York.

MEMBER—American Orthopedic Association, Western Surgical Association, Clinical Orthopedic Society, American Academy of Orthopedic Surgeons, American College of Surgeons.

Professor of Orthopedic Surgery of the University of Nebraska College of Medicine, Omaha, Nebraska.

U. J. WILE, M.D. Ann Arbor, Michigan

GRADUATE—Johns Hopkins School of Medicine, Baltimore, Maryland.

MEMBER—American Proctologic Society, American Dermatological Association, American Academy of Dermatology and Syphilology, American College of Physicians.

Professor of Dermatology and Syphilology, University of Michigan Medical School.

HOUSE OF DELEGATES

The meeting of the House of Delegates will be held on Wednesday, May 10, at 9:00 a.m. at the Hotel Kansan on the Mezzanine floor and on Thursday, May 11, at 4:00 p.m. in the Auditorium. The first regular meeting will be devoted to the reports of officers, councilors, committees and other business. The second regular meeting will include the annual election of officers and completion of unfinished business. The reference committee plan will be utilized again this year.

A reserved section will be provided at the House of Delegates meeting for the seating of Delegates. Delegates will be registered at the entrance of the meeting place which will entitle them to sit in the reserved section, which eliminates the necessity of roll call and expedites voting. Delegates are requested to present letters of authority or other certifications from their county medical society.

The Constitution and By-Laws provides that each county medical society is entitled to send to the House of Delegates each year, one duly qualified Delegate for every twenty members, and one duly qualified Delegate for each major fraction thereof; providing that each component society has made its annual report and paid its assessments as provided by the Constitution and By-Laws. In the event that a Delegate finds it impossible to attend, the By-Laws provide that he shall appoint an Alternate to attend and serve in his place and that each such Alternate shall qualify himself to the committee on credentials. Many matters of extreme importance are scheduled upon the agenda for this year's House of Delegates meetings and every county medical society is urged to have its Delegates or Alternates present at both of the meetings.

All members of the Society are invited to attend the meetings of the House of Delegates.

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Schedule of Events

85TH ANNUAL SESSION

Topeka, May 10-11, 1944

WEDNESDAY, May 10

9:00 A.M. REGISTRATION

Topeka Municipal Auditorium

9:00 A.M. HOUSE OF DELEGATES

Hotel Kansan, Mezzanine Floor

12:15 P. M. ROUND TABLE LUNCHEONS

MEDICINE-Hotel Jayhawk

Guest Speaker-Edward Massie, M.D., St. Louis, Mo.

Presiding—Harold Jones, M.D., Winfield

PEDIATRICS—Hotel Kansan

Guest Speaker—A. L. Hoyne, M.D., Chicago, Ill.

Presiding-D. N. Medearis, M.D., Kansas City

GENERAL SESSION—Assembly Room

Presiding—J. H. A. Peck, M.D.

2:00 P. M. FRACTURES AND DISLOCATIONS OF THE WRIST Robert D. Schrock, M.D., Omaha, Nebr.

The author will outline the more frequent disabilities resulting from the various types of fractures in the distal two inches of the radius and ulna. Consideration will be given to the types of fracture in varying age groups, the methods of treatment, and the complications to be avoided. Discussion of carpal injuries will be limited to the most common which are frequently overlooked in the early examinations.

2:45 P.M. MANAGEMENT OF ACUTE INFECTIOUS DISEASES IN CHILDHOOD

A. L. Hoyne, M.D., Chicago, Ill.

Three major problems will be considered: Active and passive immunization against certain diseases; choice of therapeutic measures; and home and hospital care. Increased tendency to use multiple methods of immunization referred to. The declining virulence observed among the common contagious diseases is cited. New drugs and improved methods have simplified treatment. Isolation hospitals' chief value is for teaching purposes; training student nurses and medical students in the proper care of contagious diseases.

3:30 P. M. INTERMISSION Visit Exhibits

3:45 P.M. NEWER ASPECTS IN MANAGEMENT OF HYPERTENSION

Edward Massie, M.D., St. Louis, Mo.

The treatment of essential hypertension remains one of the unsatisfactory chapters in therapeutics. On the other hand, the pathogenesis of arterial hypertension so far as the underlying physiologic and morphologic processes are concerned is fairly well established. In many instances no method at our disposal will serve to lower the blood pressure for any significant length of time. In other instances the blood pressure can be reduced for a longer period with beneficial

effect. The treatment is still symptomatic rather than ideally etiologic. Yet one cannot assume too pessimistic an attitude for there can be no doubt that in many cases much can be done for the patient in controlling the manifestations of the disease and in combatting its complications.

There is as yet no specific therapy in essential hypertension. Thiocyanate therapy continues to enjoy considerable favor despite occasional untoward effects. Further experience with extracts of kidney tissue have yielded rather inconclusive results, and this form of therapy must still be considered in experimental stage. A substance contained in fish oils appears to have an anti-hypertensive effect and further study in this field is indicated. The use of tyrosinase, an enzyme specific in altering phenolic compounds has been shown to lower blood pressure but apparently not by its enzymatic action; continued investigation with this material is warranted. In very selected cases, unilaterial nephrectomy results in an occasional dramatic response. The most consistently good results appear to have been obtained following surgical therapy in properly selected cases with use of the newer technic of two-stage bilateral transdiaphragmatic splanchnicectomy and sympathetic ganglionectomy described by Smithwick.

4:30 P. M. RENAL TUBERCULOSIS

William G. Gordon, M.D., Kansas City, Kans.

Renal tuberculosis, despite the fact that it is not a common urinary tract infection, is frequently unrecognized until advanced, and often irreversible bladder involvement is present. It must be considered, therefore, when any infection of the urinary tract fails to respond rapidly to the modern chemotherapeutic agents.

The present discussion is a review of the pathogenesis of urinary tract tuberculosis, with practical consideration of diagnosis, differential diagnosis, and treatment of this disease.

7:00 P. M. BANQUET Hotel Kansan-Roof Garden

CONVALESCENT REHABILITATION PROGRAM IN THE ARMY AIR FORCE

Howard A. Rush, Lt. Col. M. C., Washington, D. C.

A summary of experience of over 22,000,000 man-hours of physical and mental reconditioning of thousands of soldier-patients in AAF. hospitals, which has resulted in (a) Sending men back to duty in "top" physical condition; (b) reducing hospital readmissions; (c) utilizing heretofore wasted convalescent time for furthering the military education of the soldier-patient and increasing his general knowledge during the period of convalescence, and other medical statistics.

THURSDAY, MAY 11

9:00 A.M. REGISTRATION

GENERAL SESSION—Assembly Room

Presiding-H. N. Tihen, M.D., Wichita

9:30 A.M. PHYSICAL THERAPY IN THE OFFICE

John S. Coulter, M.D., Chicago, Ill.

The author will discuss heat, designs for making a baker, exercise and designs for making exercise apparatus. There will be slides to illustrate heat, massage and exercise in arthritis and injuries.

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10:15 A. M. RECENT ADVANCES IN SYPHILIS THERAPY

U. J. Wile, M.D., Ann Arbor, Mich.

The United States Public Health Service program of control of infectious syphilis as carried out in various rapid treatment centers throughout the country, will be discussed. Mention will be made of multiple syringe technique; five and eight day drip methods; fever combined with chemotherapy in a one-day treatment; and, finally, penicillin. Emphasis will be placed upon the fact that none of these methods are so-called syphilis cures but represent experimental efforts to control infectious syphilis.

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11:00 A.M. INTERMISSION

Visit Exhibits

11:15 A.M. SURGICAL MANAGEMENT OF PULMONARY SUPPURATIVE DISEASE

O. Theron Clagett, M.D., Rochester, Minn.

Pulmonary suppurative disease includes lung abscesses, bronchiectasis and infected lung cysts. These conditions are amenable to surgical management. The results are most satisfactory when an early diagnosis is made and operation performed. The diagnosis and management of these lesions will be discussed.

12:15 P.M. ROUND TABLE LUNCHEONS

OBSTETRICS—Hotel Kansan

Guest Speaker—M. Edward Davis, M.D., Chicago, Ill. Presiding—Porter Brown, M.D., Salina

PUBLIC HEALTH (V. D.)—Hotel Kansan

Guest Speaker—U. J. Wile, M.D., Ann Arbor, Mich. Presiding—O. W. Davidson, M.D., Kansas City

EYE, EAR, NOSE AND THROAT—Hotel Jayhawk

Guest Speaker—A. D. Ruedemann, M.D., Cleveland, Ohio Presiding—J. G. Janney, M.D., Dodge City

SURGERY-Hotel Jayhawk

Guest Speaker—O. Theron Clagett, M.D., Rochester, Minn. Presiding—L. S. Nelson, M.D., Salina

GENERAL SESSION—Assembly Room

Presiding—C. H. Benage, M.D., Pittsburg

2:00 P.M. HEADACHES AND HEAD PAINS OF INTEREST TO THE GENERAL MAN

Presiding—J. A. Billingsley, M.D., Kansas City A. D. Ruedemann, M.D., Cleveland, Ohio

2:45 P. M. INTERMISSION

Visit Exhibits

3:00 P. M. DIAGNOSISS AND TREATMENT OF HEMORRHAGE IN PREGNANCY

M. Edward Davis, M.D., Chicago, Ill.

3:45 P. M. INTERMISSION

Visit Exhibits

4:00 P. M. HOUSE OF DELEGATES

Assembly Room

Eye, Ear, Nose and Throat Section

Auditorium, Room 101

WEDNESDAY, MAY 10

Presiding-E. N. Robertson, M.D., Concordia

2:00 P. M. THE PROTRUDING EYE—DIFFERENTIAL DIAGNOSIS
AND TREATMENT
A. D. Ruedemann, M.D., Cleveland, Ohio

3:00 P. M. INTERMISSION Visit Exhibits

3:45 P. M. OCCULAR THERAPEUTICS A. D. Ruedeman, M.D.

7:00 P.M. BANQUET

Hotel Kansas, Roof Garden

THURSDAY, MAY 11

Presiding-Louis R. Haas, M.D., Pittsburg

9:30 A. M. LESIONS OF THE CHIASMAL AREA A. D. Ruedemann, M.D.

10:15 A. M. TOXIC AMBLIOPIA—RETROBULBAR NEURITIS A. D. Ruedemann, M.D.

11:00 A. M. INTERMISSION Visit Exhibits

12:15 P. M. EYE, EAR, NOSE AND THROAT LUNCHEON

Hotel Jayhawk

Cycet Specker, A. D. Byedoman, M.D.

Guest Speaker—A. D. Ruedemann, M.D. Presiding—J. G. Janney, M.D., Dodge City

2:00 P. M. GENERAL SESSION MEETING
Assembly Room

HEADACHES AND HEAD PAINS OF INTEREST TO THE GENERAL MAN

A. D. Ruedemann, M.D., Cleveland, Ohio Presiding—J. A. Billingsley, M.D., Kansas City

REGISTRATION

The Constitution and By-Laws of the Society provide that all physicians attending the annual session must be registered before they are entitled to attend any of the events of the meeting. The only requirement for registration at the 1944 annual session is your 1944 membership card. Registration by any other means requires certification by the secretary of the county society of place of residence, or by an officer of the Society. Registration headquarters will be located at the entrance to the Topeka Municipal Auditorium.

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SCIENTIFIC EXHIBITS

UNIVERSITY OF KANSAS SCHOOL OF MEDICINE—Lawrence

DEPARTMENT OF ANATOMY

1. The Anatomy of Caudal Anesthesia—C. W. Asling, M.D.

2. Complete Absence of Inferior Vena Cava in an Adult-H. B. Latimer, Ph.D.

DEPARTMENT OF BACTERIOLOGY

- 1. Modern Methods in Virus Study-Cora Downs, Ph.D.
- 2. Penicillin-Charles B. Drake, Ph.D.

DEPARTMENT OF BIOCHEMISTRY

1. Micro-Methods of Blood Analysis-C. F. Nelson, M.D.

DEPARTMENT OF PHYSIOLOGY

- 1. Effect of Nerves on Heart Action as Shown by Electrocardiographic Records—O. O. Stoland, Ph.D.
- 2. Relative Efficiency of Schafer Prone-pressure and Teeter-board Methods of Resuscitation of Lung Ventilation—Parke Woodard, M.D.

DEPARTMENT OF ZOOLOGY

Mary Larson, Ph.D.

FORENOON SESSION, MAY 10

Demonstration of complete life cycles of Plasmodium vivax (tertian malaria) and Plasmodium falciparium (subtertian malaria) in the blood stream of man. Also smears of sporozoites from the salivary gland of the mosquito and a section of the stomach wall with oocytes in situ.

AFTERNOON SESSION, MAY 10

The same for Plasmodium malaria (quartan malaria). Also slides showing Try-panosoma gambiense (African sleeping sickness) and Trypanosoma Cruize (S. American sleeping sickness) and smears of Leishmania bodies.

FORENOON SESSION, MAY 11

Demonstration of the vegetative and cystic stage of six amebae known to inhabit the digestive tract of man.

AFTERNOON SESSION, MAY 11

The same for the intestinal flagellates, ciliates and sporozoa. Also slides showing the micro-filaria of Wucherria bancrofti. (Often involved in Elephantiasis) and smears from tumor content of Onchoceca vulvulus (eye worm of Mexico and Central America).

UNIVERSITY OF KANSAS SCHOOL OF MEDICINE—Kansas City

DIGITALIS DOSAGE

ACUTE RHEUMATIC FEVER AND ITS COMPLICATIONS

Don Carlos Peete, M.D.

PATHOLOGY OF GALL BLADDER

Dean H. R. Wahl and G. A. Walker, M.D.

KANSAS STATE BOARD OF HEALTH

DEMONSTRATION OF THE PHOTOROENTGEN UNIT

DATA AND GRAPHS OF THE WORK IN VARIOUS DEPARTMENTS

(Including data on the 1943 poliomyelitis epidemic)

STATE SANITORIUM FOR TUBERCULOSIS, Norton

C. F. Taylor, M.D., Superintendent Films of various tubercular lesions.

TOPEKA ARMY AIR BASE

EMERGENCY

First Aid Equipment and Methods.

BONE TUMORS

L. K. Chont, M.D., Winfield-The Snyder Clinic

SURGICAL TREATMENT OF PROGRESSIVE DEAFNESS

Laverne B. Spake, M.D., Kansas City.

TRANSPARENCIES OF VARIOUS SKIN LESIONS

George L. Gill, M.D., Sterling-Trueheart Clinic.

VISUAL ESTIMATION OF DIETS

Thos. P. Haslam, Council Grove.

Events for Women

The Women's Auxiliary to the Kansas Medical Society extends a cordial invitation to the wives of the members to attend the meetings to be held in Topeka on May 10 and 11, 1944, at the Hotel Jayhawk.

WEDNESDAY, MAY 10

9:30 A.M. REGISTRATION AND CREDENTIALS

Hotel Jaybawk

10:00 A.M. PRE-BOARD MEETING

Hotel Jaybawk

12:00 PAST PRESIDENTS LUNCHEON

Hotel Jaybawk

3:00 P.M. TEA-GOVERNOR'S MANSION

7:00 P.M. BANQUET—KANSAS MEDICAL SOCIETY

Hotel Kansan Roof Garden

THURSDAY, MAY 11

9:15 A.M. REGISTRATION

Hotel Jayhawk

9:30 A.M. GENERAL MEETING

Hotel Jayhawk

Election and Installation of Officers

12:00 LUNCHEON

Hotel Jayhawk

Speaker—Mrs. Eben J. Carey, Wauwatosa, Wisc. National President, Women's Auxiliary

2:00 P.M. TOUR-WINTER GENERAL HOSPITAL

COMMITTEE CHAIRMEN—1944 MEETING

Mrs. J. L. Lattimore-General Chairman

Mrs. W. M. Mills-Tea Chairman

Mrs. P. M. Powell-Program Chairman

Mrs. H. H. Wood—Courtesy and Registration Chairman

Mrs. Vernon Wiksten-Luncheon Chairman

Mrs. E. H. Decker—Chairman Winter Hospital Tour

President's Message

Looking back over the year we feel that much has been accomplished. We have adjusted ourselves to the changes brought about by the war and are making a concerted effort to help the nation in its war program through the many activities proposed by the National Auxiliary. All of the established chairmanships have carried on as usual, but the program of War Participation has been emphasized in all the county organizations. It has been very gratifying to read in the reports that many hours of work have been given by our members to teaching first aid, home nursing, and nutrition classes, making supplies for Red Cross, working as Nurses'

Aids, serving hot lunches for children, helping in canteens, presenting health programs over the radio, assisting with the cancer control program, and contributing to the infantile paralysis campaign, tuberculosis association and Red Cross. Also some of our members are helping in their husbands' offices. Other local projects have been sponsored by our members to help the community health. All are to be commended for this patriotic service.

When everyone is so busy, it is difficult to know just what activity to give preference, but members are encouraged to take an active part in Auxiliary APRIL, 1944 121

work even if other duties demand a great deal of time. Be loyal and help the Auxiliary keep what others have worked so hard to build for it is something of which all should be proud. Some extra



MRS. E. E. TIPPIN

effort now will assure the future of the Auxiliary.

On March 13, I was the guest of my own Sedgwick County Auxiliary at a luncheon meeting. Labette County Auxiliary entertained for me on March 22 with a tea in the home of Mrs. T. D. Blasdel and a dinner in the private dining room at Kansas Ordnance Plant. Mrs. J. T. Naramore, county president, and Mrs. T. D. Blasdel were my hostesses. Central Kansas invited me to their meeting on March 30. It was held in the home of Mrs. F. N. White of Russell. After the meeting tea was served. These three meetings were very enjoyable and the reports encouraging; they will stand out as highlights in the year's work. This month I'm looking forward to my visit to Shawnee and Wyandotte Auxiliaries.

It has been the cooperation between the state officers and chairmen and the county units that has made it possible to accomplish what we have this year. I wish to thank each one for their faithful work and "willingness to do" in every way asked. It has made this year a pleasant one, and I appreciate the privilege of serving with you as President.

Sincerely,

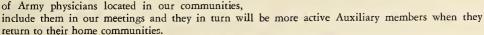
Mrs. E. E. Tippin

PRESIDENT-ELECT'S MESSAGE

As we complete the nineteenth year of our organization, it is well to think back over the years the Woman's Auxiliary to the Kansas Medical Society has been functioning, realize what we have accomplished and look forward to the coming years. Knowledge of the future fortunately is concealed from us, but as the picture unfolds itself we see need for strong leadership and co-operation. The national program of "Health and Post War Planning" is most timely and will be used as a slogan for the year 1944-1945.

Realizing that "an Auxiliary is only as strong as each individual member," let us strengthen our country and state Auxiliary by individual efforts, co-ordinated with the group organization and stamped with the approval of the medical Society. Health and war-time efficiency are inseparable and we as Auxiliary members must have the determination and courage to be leaders in this health program. We have a responsibility at this time graver than ever before. We must keep ourselves informed on health and legislation so that we may serve the medical profession and through it the public.

Let us offer a service of friendliness to the wives of Army physicians located in our communities,



In the coming year, with your co-operation let us have the strongest and most active Auxiliary in the United States.



MRS. LEO J. SCHAEFER

Sincerely, Mrs. Leo J. Schaefer.

Kansas Medical Assistants Society

1944 Annual Meeting, Wichita, May 12

The Kansas Medical Assistant's Society extends a cordial invitation to all doctors' assistants who are members of the Kansas Medical Society to attend the annual meeting in Wichita on May 12, 1944. The registration fee for the meeting is \$3.00.

SCHEDULE OF EVENTS

THURSDAY, May 11

8:00-10:00 P. M. REGISTRATION AND OPEN HOUSE Hotel Allis

FRIDAY, May 12

8:30 A. M. REGISTRATION

Hotel Allis, Mezzanine Floor

9:30 A.M. COUNCILOR MEETING

10:00 A. M. ADDRESS OF WELCOME

Zura Crockett, Wichita, President, Sedgwick County Medical Assistants Society.

RESPONSE

Marjorie Euler, Topeka, President-Elect, Shawnee County Medical Assistants Society.

11:00 A.M. THE DOCTOR AND HIS ASSISTANT

Mr. Oliver Ebell, Wichita, Executive Secretary, Sedgwick County Medical Society.

11:30 A.M. OPEN DISCUSSION

12:00 LUNCHEON

Hotel Allis, Ball Room

Presiding-Zura Crockett, Wichita

Invocation-Katherine Millsap, Deaconess, Wesley Hospital, Wichita

Piano Selection-Mrs. Jack Benson, Wichita.

WHAT THE WAR HAS DONE TO THE DOCTOR'S OFFICE

Senator Henry J. Allen, Wichita

1:30 P.M. BUSINESS MEETING—ELECTION OF OFFICERS

Presiding-Edna Nichols, President, the Kansas Medical Assistants Society

COMMITTEE CHAIRMEN—ANNUAL MEETING

Zura Crockett-General Chairman

Donna Harrison—Luncheon Chairman
Shirley Drake—Decorations Chairman

Margaret Holtsclaw—Chairman on Prizes

Reginia Lewis—Chairman on Publicity

Charlotte Parrish—Entertainment Chairman Dolly Harrington—Registration Chairman

TECHNICAL EXHIBITORS

The Technical Exhibitors contribute a great deal to the state meetings of any medical society, in financial assistance, new and unusual equipment shown and the display of their products contribute considerable scientific information. Kansas, as in years past, has again been fortunate in the number of fine exhibits which will be shown at the 1944 meeting. These companies have spent considerable time, effort and money in bringing their most interesting displays to you for your inspection and members of the Society can do much to fulfill our obligation by visiting and registering at the booths.

TECHNICAL EXHIBITORS—EIGHTY-FIFTH ANNUAL SESSION

- 1. A. S. Aloe Company, St. Louis, Mo.
- 2. E. R. Squibb & Sons, New York, N. Y.
- 3. Sharp & Dohme, Inc., Philadelphia, Pa.
- Holland-Rantos Company, Inc., New York—Chicago
 —Los Angeles
- 5. Petrogalar Laboratories, Inc., Philadelphia, Pa.
- 6. John Wyeth and Brothers, Philadelphia, Pa.
- 7. S. M. A. Corporation, Philadelphia, Pa.
- 8. Pet Milk Corp., St. Louis, Mo.
- 9. Wm. S. Merrell Company, Cincinnati, Ohio.
- 9A. American Hospital Supply Corp.
- 10-11. General Electric X-Ray Corp., Kansas City, Mo.
- Goetze-Niemer Company, Topeka—Kansas City— St. Joseph.
- 13. Greb X-Ray Company, Kansas City, Mo.
- 13A. Farnsworth Leboratories, Chicago, Ill.
- 14. Blue Cross, Topeka, Kans.
- Similac (M & R Detetic Laboratories), Kansas City, Mo.
- 16. Mead Johnson Company, Evansville, Ind.
- 17. Mid-West Surgical Company, Wichita, Kans.
- 18. Ortho Products, Inc., Linden, N. J.
- 19. W. E. Isle Company, Kansas City, Mo.
- 20. Parke, Davis and Company, Detroit, Mich.
- 21. The Borden Company, New York, N. Y.
- 22. Gerber Products Company, Fremont, Mich.
- 23. The Medical Protective Company, Fort Wayne, Ind.
- 24. Eli Lilly Company, Indianapolis, Ind.

Booth 1 A. S. ALOE COMPANY St. Louis, Missouri

"A. S. Aloe Company of St. Louis and Kansas City are displaying a cross-section of their complete line of surgical and laboratory equipment, instruments and supplies. Featured will be American made stainless steel instruments which are available under todays conditions, as well as exclusive Aloe specialities such as the Radcliff Retractor for perineal repair, the Goth set for simple and rapid determination of Sulfonamide concentration in the blood."

Booth 2 E. R. SQUIBB & SONS New York, New York

"Physicians attending the Kansas Medical Society meeting are cordially invited to visit the Squibb exhibit, booth 2. Several new items will be shown. Among them is Intocostrin, the standardized Purified Curare Extract now widely used to soften convulsion in shock therapy; a new, highly useful therapeutic multi-vitamin preparation; a sulfathia-ole-ephedrine-derivative combination for ophthalmic use."

Booth 3

SHARP & DOHME, INC.

Philadelphia, Pennsylvania

"Sharp & Dohme will have their display at booth No. 3 featuring their new sulfonamide, Sulfamerazine, and also

'Sulfasuxadine', 'Lyovac' normal human plasma, Tyrothricin Concentrate (human), 'Depropanex', 'Delvinal' Sodium, 'Propadrine' Hydrochloride products and 'Lyovac' Tetanus Antitoxin, bovine. Capable, well-informed representatives will be on hand to welcome all visitors and furnish information on Sharp & Dohme products."

Booth 4

HOLLAND-RANTOS COMPANY, INC.

New York—Chicago—Los Angeles

"Koromex Set Complete—a complete unit for contracepuve technique. Provides for patient comparison of jelly and cream. Contains, in a handsome case; Koromex diaphragm with special pouch; Koromex Trip Release Introducer (takes all sizes diaphragms); Tube Koromex Jelly (higher lubricating factor); Tube Koromex Cream (lower lubricating factor); Set Dickinson-Freret Fitting Charts."

Booth 5

PETROGALAR LABORATORIES, INC.

Division Wyeth Incorporated Philadelphia, Pennsylvania

"You are invited to visit the Petrogalar Laboratories booth where our representatives will be pleased to suggest new uses for Petrogalar in your practice."

Booth 6

JOHN WYETH AND BROTHERS

Division, Wyeth Incorporated

Philadelphia, Pennsylvania

"You are cordially invited to visit the Wyeth exhibit where Amphojel, Phosphaljel, Bepron, B-Plex will be featured and other Pharmaceutical specialties."

Booth 7

S. M. A. CORPORATION

Division, Wyeth Incorporated Philadelphia, Pennsylvania

"Up-to-the-minute information on Infant Feeding and Nutritional Biochemicals can be obtained at the S.M.A. Corporation booth. Of particular interest to most physicians is the new protected Vitamin A. product, Caritol."

Booth 8

PET MILK SALES CORPORATION

St. Louis, Missouri

"A complete display of material illustrating the timesaving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit."

Booth 9

THE WM. S. MERRELL COMPANY

Cincinnati, Ohio

"Particular attention is called to a new development of Merrell Research for local treatment of pyogenic infections—SULFA-CEEPRYN CREAM, which employs the unique detergent-germicide, Ceepryn, to reinforce the balance bacteriostatic action of sulfathiazole and sulfanilamide. Other Merrell prescription specialties of established usefulness in clinical medicine also will be displayed."

Booth10-11

GENERAL ELECTRIC X-RAY CORPORATION

Kansas City, Missouri

"The General Electric X-Ray Corporation's exhibit will be in charge of Mr. C. F. Falk and Mrs. J. F. Van Osdell. They will be pleased to help you with any problem you may have in x-ray and to discuss with you any plans you may have for the purchase of x-ray equipment. Besides exhibiting x-ray supplies, we expect to be able to show you the new line of Stader Splints. We hope that you will visit our booth so that we may have the opportunity and pleasure of seeing you."

Booth 12

GOETZE NIEMER COMPANY

Topeka-Kansas City-St. Joseph

"The Goetze Niemer Company of Topeka, Kansas City and St. Joseph will only exhibit Nationally known trademarked supplies and equipment selected by Dr. W. F. Goetze, (a member of the A.M.A.) who in directing the conservation policies of his company for over fifty years has used his intimate knowledge of the requirements of the Kansas Medical profession to anticipate and facilitate satisfactory solutions of supply and equipment problems."

Booth 13

GREB X-RAY COMPANY

Kansas City, Missouri

"Attending physicians are cordially invited to visit with the representatives of the Greb X-Ray Company. You will be interested to discover what is new in x-ray equipment and our entire facilities are at your disposal. With the lifting of restrictions on the distribution of x-ray equipment you will want to start planning now for that new department that has been put off too long."

Booth 15

M & R DIETETIC LABORATORIES

Kansas City, Missouri

"M & R Dietetic Laboratories, booth No. 15, will display Similac, a food for infants deprived partially or entirely of breast milk; also SofKurd. Mr. Ben Palmer will appreciate the opportunity to discuss the merit and suggested application of these products."

Booth 16

MEAD JOHNSON & COMPANY

Evansville, Indiana

"'Servamus Fidem' means 'We Are Keeping the Faith.' Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum and other infant diet materials-including the new pre-cooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to booth No. 16 will be time well spent.'

Booth 18

ORTHO PRODUCTS, INCORPORATED

Linden, New Jersey

"Ortho's exhibit will feature their Council Approved products for the control of conception. Booklets, reprints, et cetera, dealing with the various methods, will be distributed. Ask for the recently published physicians booklet, 'Studies in Human Fertility,' which deals with the many aspects of fertility control."

Booth 19

W. E. ISLE COMPANY

Kansas City, Missouri

"W. E. Isle Company invites each registrant to its booth. Well informed representatives will gladly discuss the newer appliances and furnish information about the products



displayed. Artificial limbs, orthopedic appliances, surgical supports, maternity belts, elastic hosiery, trusses -you prescribe one or more of these articles frequently. Take this oppor-

tunity to examine the complete line of Isle Products.'

Booth 20

PARKE, DAVIS AND COMPANY

Detroit, Michigan



"You will find displayed at the Parke-Davis booth many outstanding pharmaceuticals and biologicals. Included in this technical exhibit are such noteworthy products as Phemerol, a new type of germicide and

antiseptic; Adrenalin Preparations; Mapharsen; Theelin; Despeciated Antitoxins; also other therapeutic agents of cursent interest. You are cordially invited to visit this exhibit."

Booth 21

THE BORDEN COMPANY

New York, New York

"At booth 21 the Borden Company has on display a distictive and outstanding line of scientifically designed infant formula foods. Among these products there is a formula to meet the varied needs of your individual infant feeding cases. Stop by for details on Biolac, the liquid, complete modified milk formula (except for vitamin C); Dryco, the dried, high-protein, low-fat milk food that offers wide formula flexibility; Mull-Soy, the special, liquid dietary soy bean food for patients allergic to milk. Also Klim, Beta Lactose, Merrell-Soule Powdered Milks and Borden's Irradiated Evaporated Milk."

Booth 22

GERBER PRODUCTS COMPANY

Fremont, Michigan

"Gerber's Cereal Food and Strained Oatmeal are enriched and precooked. We invite your inspection of the literature and the display of the Gerber Foods."

Booth 23

THE MEDICAL PROTECTIVE COMPANY

Fort Wayne, Indiana

"The Medical Protective Company's representative, thoroughly trained in professional liability underwriting, invites you to visit exhibit booth No. 23. He is entirely familiar with the principles of the reciprocal rights and duties of a doctor and patient and with the circumstances peculiar to that relationship. He will be glad to explain how his company meets the exacting requirements of adequate liability protection, which are peculiar to the professional liability field."

Booth 24

ELI LILLY AND COMPANY

Indianapolis, Indiana

"The Lilly exhibit will feature an anatomical model illustrating the technics of caudal and spinal anesthesia. Lilly products will be on display, and medical service representatives will be present to assist visiting physicians in every possible way."

Booth 25

BURROUGHS WELLCOME & COMPANY, INC.

New York, New York

"Burroughs Wellcome & Co., New York presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession."

President's Page

To the Members of the Kansas Medical Society:

The past year has presented many problems for consideration of Kansas physicians and these can only be solved if we consider the welfare of the public as well as our own individual situations.

The coming House of Delegates will be asked to make many important decisions and I desire that so far as possible we discuss these matters within our own groups and endeavor to have a working knowledge so that we can accomplish these things in a short time.

Dr. Harold Jones will present the matter of the post graduate program, covering his committee's idea as they pertain to a wide, long-range graduate study, both for the returning men from the service as well as men in practice at home. His committee desires to raise a fairly large sum on a voluntary basis, to accomplish this result.

Dr. B. A. Nelson will present his committee's report on a plan for insurance covering indemnity for certain costs associated with orthopedics, surgery and obstetrics. His committee, and I agree, feels that some plan along this line is almost essential. In a recent survey, some eighty per cent of those interviewed feel that some plan should be developed enabling people to meet the unusual expenses connected with sickness. It was interesting, however, that only six per cent feel that they would like to have complete coverage.

There is a considerable tangle about the opening of a Washington office by medical representatives. One group, operated by the United Public Health League, representing six far Western states has already opened their office, with Mr. Ben Read in charge. Within the past few weeks the Council on Medical Service of the American Medical Association has announced that they will open an office. The Association of American Physicians and Surgeons, Inc., of Indiana, has announced that it will open an office. Both the A. A. P. S. and the United League are asking our state Society to endorse them. This matter will at least be discussed at the House of Delegates.

Dr. Raymond Gelvin is heading the committee to make a study of possible group insurance. They will not have enough data to report at the coming meeting but will continue their work.

I desire to thank the various committees for their work and for the very excellent cooperation of the members of the Society. You have been exceedingly tolerant of the mistakes that I have made, which are many.

I can only ask that you look to the future under the excellent direction of our incoming President, Dr. Marion Trueheart, and that you give him the wholehearted support you have given to me.

Sincerely,

President, the Kansas Medical Society

EDITORIAL

THE RETIRING PRESIDENT

Dr. John L. Lattimore, retiring President, has won the plaudits of the entire membership for his able direction of our professional activities in the past year. The work of a medical society in war time increases perceptibly and the changes in the execu-

tive secretaries office, during the past year, have added materially to his Society duries.

Early in his presidency he appointed the committees which have served so ably under his direction. Post graduate work has been of increased importance and much has been planned along this line for the future. The Emergency Maternal and Child Care program under federal appropriation and the State Board of Health supervision has been in active operation in the state. Plans for the new program for the prepayment of surgical, obstetrical and emergency care of the civilian population under the supervision of the Society have been well developed, under Dr. Lattimore's supervision.

A man of dynamic personality, Dr. Lattimore has done a splendid job during the past year in the handling of unforseen problems affecting the profession as a whole under the burden of a country at war. He is the owner and director of the Lattimore Laboratories in Topeka, and El Dorado, Sedalia, Missouri, and McAlester, Oklahoma, and is the pathologist at Christ's, St. Francis and Jane C. Stormont hospitals in Topeka. He served in the Medical Corps in World War I, is a Fellow of the American Medical Association, a Diplomate of the American Board of Pathology, served as President of the American Society of Clinical Pathologists in 1941-1942, was Councilor of the Society for the Fourth District, a member of the Board of Directors of the Kansas Group Hospital Service, Inc. (the Kansas Blue Cross), a member of the Board of Regents of Washburn Municipal University of Topeka, and a member of the Kansas State Board of Health.

All who have worked with Dr. Lattimore know of his sincere interest in the welfare of the profession in the state and nation. He has been most active in his attendance at meetings and his speaking contacts have been many and the subjects varied, all in the interest of medicine. He has spent innumerable hours in the central office directing the activities of all groups and movements. Dr. Lattimore will long be remembered for his capable leadership of Kansas medicine.

85th ANNUAL SESSION

The members of the Shawnee County Medical

Society as hosts enxtend to you a cordial invitation to attend the 85th Annual Session of the Kansas Medical Society which will be held in Topeka on Wednesday, May 10, and Thursday, May 11.

The 1944 meeting has been stream-lined to wartime attendance and planned to interest the specialist and general practitioner alike and the program will include the following subjects: venereal disease; eye, ear, nose and throat; penicillin; surgery; obstetrics; pediatrics and the rehabilitation of war wounded. The complete program and list of guest speakers will be found in this issue of the Journal and includes some of the best informed men in their respective professional fields. The scientific and tech-

nical exhibits will be replete with modern medical information and give added interest to the meeting. The House of Delegate meetings have been scheduled to avoid any conflict with the scientific session and much of interest to the profession of Kansas will be discussed.

The Kansas Obstetrical and Gynecological Society will hold a meeting on Thursday, May 11, at the Hotel Jayhawk and following the luncheon an election of officers will be held. The Eye, Ear, Nose and Throat Society has planned a complete program and in addition their guest speaker will give a talk before the general assembly on a subject of interest to the entire profession.

Due to the cancelation of last year's scientific meeting and the condensation of program time the meeting should be well attended. The golf and trap shoot and the annual dance have been dispensed with but the program has been well planned for your edification and enjoyment. If you have not already



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made plans to attend the meeting in Topeka we suggest that you do so at once. You will find that the two days will give a beneficial change from your usual professional routine, lend a zest in the renewal of old acquaintances and stimulate new interests and scientific knowledge.

NEW PRESIDENT

The Kansas medical profession welcomes Dr. Marion Trueheart of Sterling as the new President

of the Society for 1944-1945.

Dr. Trueheart was born in Sterling in 1881, attended the Kansas City Medical College from which he was graduated in 1904 and interned in Kansas City and at Johns Hopkins Hospital in Baltimore, Maryland. In July of 1918 he was sent over sea to serve as a Captain in the Medical Corps and saw considerable action.

Dr. Trueheart has been an active leader in the Society for many years, having served as its Second Vice-President in 1941-1942, its First Vice-President in 1942-1943, its President-Elect in 1943-1944, as Councilor of the Fifth District from 1935-1941, the maximum period of

two terms and as a member of many Society committees in the past years.

He is a Fellow of the American Medical Association, a Fellow of the American College of Surgeons, a member of the American Board of Radiology, American Radium Society, Radiology Society of North America, Inc., and the American Urological Association.

Dr. Trueheart has been selected to guide the medical profession of the state in the coming year of peace or war adjustment. He has long been a leader in the profession and the membership has chosen a worthy man to add to a long line of capable and efficient Presidents.

THE PROPOSED KANSAS PHYSICIANS' SERVICE

Barrett A. Nelson, M.D.*

Manhattan, Kansas

A poll of American opinion reported by Fortune Magazine in 1942 showed seventy-four per cent of the population of the United States in favor of some form of government insurance to cover medical care. In that same year President Roosevelt in his budget message to Congress recommended that the Social Security law be amended to provide for hospitalization benefits. From that recommendation have stemmed the various visionary schemes for national socialization of medicine finally culminating in the much discussed Wagner-Murray-Dingell Bill.

At a meeting of state medical society secretaries in 1943, officers of the American Medical Associa-

tion urged the study and adoption of pre-payment plans for medical care. It was felt that if such plans had been widely adopted during the preceding two-year period, the Wagner-Murray - Dingell Bill would never have come before Congress. In the Journal of the American Medical Association of February 12, 1944, an editorial stated, "The House of Delegates of the American Medical Association has repeatedly adopted resolutions encouraging state and county medical societies to organize experimental pre-payment plans. Many such plans - at least twenty - several of them state-wide, are now in opera-

tion, or in process of organization. The first was begun about six years ago; now approximately a million members are receiving medical care through such plans. (Comparing them to compulsary plans) medical society plans make good medical care the stable element to which all else must be adjusted. . . . (They) grow and develop with the progress of medicine and the health needs of the public."

Last year the California Medical Society conducted an extensive survey to study voluntary health plans in California. The report of the findings with recommendations appeared in the November 1943 issue of California and Western Medicine in which it was stated, "Unless the medical profession and hospitals can make adequate care available through voluntary pre-payment health plans, there will be a public demand that government provide health services. As a matter of fact, such demand already exists. It is however, not too late for the profession and hospitals to meet the public demand in a voluntary non-profit way."

The National Physicians Committee has recently released a comprehensive report of the findings of



^{*} Chairman of the Committee on Medical Economics of the Kansas Medical Society.

a nation-wide poll of American opinion relative to medical care. All economic levels, large urban, small urban and rural communities were polled. What is believed to be an extremely accurate gauge of public opinion was obtained. This study led to the conclusion, "The people sense the need for an extension of facilities designed to aid in meeting the costs of unusual or prolonged illness." Of those who expressed an opinion, eighty-five per cent "think something might be done to make it easier to pay medical or hospital bills." Seventy-one per cent of this group said that pre-payment, insurance or installment plans would answer the need. Of those to whom the question was put, eighty-six per cent said, "Some plan of easy payment must be provided for the payment of costs for unusual and serious emergencies." A study was made of various types of pre-payment plans including co-operative groups, company or employee medical service plans, regular insurance company group policies, private clincs, medical society sponsored plans, et cetera, and "it is estimated that such programs now provide prepayment facilities for approximately 25,000,000 people." Of those obtaining benefits under such plans eight and one-half times as many thought they were better off with such service as compared with those who thought they were not. The doctors working under the plans were polled and the large majority expressed the belief that they benefit by being under such plans and stated "it would be a good thing if all industries in the nation would operate pre-payment medical and hospital service plans for their employees." In summary, "The American people know about and desire—demand—a plan or plans—a method for the pre-payment of medical care costs. This demand must be met."

In January the Councilors of the Kansas Medical Society directed that the Chairman of the Committee on Medical Economics should attend, on February 12, the Chicago meeting of the Medical Service Plans Council, an organization composed of the various physician-sponsored plans now in operation in various states. At this meeting speakers presented the accomplishments, the progress made, the mistakes overcome, the needs to be met, and the problems faced by those plans now functioning. Discussions were held in open forum for analysis of the difficulties confronting them. Representatives of the government were also present or quoted on the matter.

One of the latter was the Honorable Walter H. Judd, M.D., Congressman from Minnesota, one of seven doctors now in Washington representing their constituencies. In his inspiring address he said, in part, "We cannot ignore the fact that the quality and distribution of medical care in America today is inadequate and imperfect. This does not affect a large

proportion, perhaps less than ten per cent. At least eighty to ninety per cent of our population has the best medical care in the world. There are groups, however, who focus their attention only on the ten per cent, and then plan to scrap the ninety per cent good to salvage the minority. Moreover, these groups have access to machinery that is influential and they mean to carry their program. . . . It now rests with us to choose. If we don't lead, I promise we will have imposed on us, the solution. Of course our hope is to salvage what is good in our present system and ultimately to perfect the part that is lacking today. But we will not do that if we permit politicians to work out their own plan. In this, the relationship between the doctor and his patient is destroyed. In this plan inefficiency is upheld.... You must have a good program first. And that brings up the Wagner-Murray-Dingell Bill. It cannot pass this Congress. Thank God you have a breathing spell but it's your last chance. You've got to come through. And you have to come through with a program—the program you want."

Another speaker was Mr. Ben Read who had been sent to Washington to conduct a survey for the United Public Health League. Of numerous government officers interviewed by him, he quoted Congressman Harrison Ellsworth of Oregon as follows, "Doctors should take the lead in seeing to it that proper medical care is well distributed to the public. You cannot just hide and oppose. The medical profession itself must offer a plan for pre-paid medical service. If they don't do it, the politicians will do it for them. It is the greatest political field imaginable for votes. Think of the returning veterans, going to want some better spread of medical service for their families, and it will come. Crackpot ideas will come forth . . . doctors will oppose it ... myself and other good friends of the doctors will be in a bad spot. For the sake of your friends take the lead and give us something, not just 'no' . . . Keep it out of the hands of politicians. Approach it not from the standpoint of the welfare of the medical profession, but in giving to all the public the benefits of medical science. . . . Do it yourself or the politicians will do it for you."

American Medical Association officials again approved and urged further organization of pre-payment plans under medical society control. Dr. Leland of the Medical Economics Committee pointed out that "we have a greater interest in and a growing development of pre-payment plans," while Dr. Simond said, "There is a tremendous movement toward pre-payment plans."

The astonishing disclosure that 25,000,000 are already served by some form of pre-payment plan includes the large number covered by commercial in-

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surance company group policies. These are chiefly in the large industries who now quite generally demand such coverage for their employees. Insurance companies, alert to this demand, are rapidly capitalizing it to their profit. While the principle is sound, it is obviously not the most desirable structure from the medical practitioner's standpoint. It is organized purely for profit; the interests of the patient are subordinated; and the physician becomes a mere partner to a transaction where a commercial organiation has previously sold his services on the market. Not to mention the harassing and exasperating demands for extensive, detailed and repeated reports. Far better that such plans be administered by a nonprofit organization controlled by the chief character in the whole structure, the one whose services are being dispensed, the physician; and that operation be conducted for the benefit of the patient, not private profit.

In Kansas our excellent and rapidly growing Hospital Service Plan, the "Blue Cross," is finding this demand in industrial as well as other groups. A large group in Wichita recently purchased hospitalization insurance from a commercial company because they could obtain medical coverage from the same source. The Committee on Medical Economics already has received inquiry as to whether such a plan is offered by Kansas physicians. Interest has been shown by industries, school organizations, college faculties, and farm organizations. As an additional example of the keen scent of the commercial companies, a Baltimore finance company has already created and incorporated an insurance company for the express purpose of furnishing a medical service contract to be sold by hospital service groups along with their hospital coverage. A distinct challenge to the profession by someone else desiring to be vendors of our sevices.

The Chicago meeting was fruitful of numerous clear and startling impressions. Outstanding is the phenomenal progress and growth of physiciansponsored pre-payment plans during the short period of six years since they first appeared. Most are operating with gratifying success, the experimental beginnings being now supplanted by efficient organizations functioning smoothly and effectively. The doctors in these plans enthusiastically discussed their accomplishments and problems. Numerous additional medical societies were seeking data and information for adoption in their areas. Particularly impressive was the very evident dissolution of objection and antagonism of those who formerly criticized and opposed such plans, with the progressive and accelerated realization that these plans are proving so satisfactory to the participating physicians, the patients subscribing, industry, and the general public.

And the conviction was obtained that this rapidly spreading movement truly fills a need which has long existed in the economics of medical practice, making it possible for patients to budget against the financial strain of serious illness; that here is a method under complete control of organized medicine, which not only answers and eliminates those cynics who believe that doctors profit unduly from the unfortunates who must pay for unexpected serious illness, but also answers and deflates those demagogic politicians who would endeavor to extend medical service by submergence of private medical practice beneath a bureaucracy to fatten political job-holders and inevitably inaugurate the Modern Dark Ages for medical science.

The successful plans are remarkably similar in character. It definitely has been found that the public is not ready for a plan for overall and complete coverage. The costs are necessarily more than the purchaser of a contract is willing to pay and there is, as yet, insufficient actuarial basis for complete knowledge of proper costs. It is in this field that difficulties have arisen and such efforts have been the chief cause of failures and unhappy results. This was notably true in California, Michigan and elsewhere. Revisions to exclude all but coverage of surgical, orthopedic and obstetrical care have met with success. Such are the plans functioning so well in Massachusetts, Michigan and in Kansas City. Most of these also find it desirable to share promotional, administrative and general overhead costs with a hospital service organization. The two services are closely related; the subscriber usually wants them together; and the arrangement proves to be mutually advantageous.

The tentative plan for Kansas would be of this type, limiting coverage, for the present, to surgery, orthopedics and obstetrics. Operation would be carried on jointly with the Kansas Hospital Service Association, which has shown itself not only willing but desirous of entering into such a relationship, and which is well organized and equipped to carry on the project.

The proposed contract would present a fee schedule furnishing complete payment for the prescribed services for individuals with an annual income below \$1,800.00 (or a family income of \$2,400.00) while those with higher incomes would be expected to pay the difference between the fee schedule and the usual fee for their income levels. In other words, those in the higher income brackets would receive an indemnity payment applied against their medical costs. This is said to have proven very satisfactory where the principle is in force.

Under Kansas law the alternative to the delay of obtaining a legislative enabling act would be incor-

poration under the requirements and rulings of the State Insurance Commission. This entails a deposit of \$50,000 which may be raised by issuance of interest bearing notes to physician members. The fund may be invested and securities deposited with the Insurance Commissioner. The enthusiastic response of those to whom the matter has been broached indicates the subscriptions to this fund would be readily obtained. Experience offers assurance that gradual growth of a reserve would retire the fund within a reasonable period.

It is felt that the organization should be completely under control and direction of members of the Kansas Medical Society with 100 per cent membership on the Board of Directors and no division of control with any other organization nor any lay members except as administrative employees.

The name, Kansas Physicians' Service, has been suggested as presenting the service to be offered and specifically indicating that it is sponsored, and the service directly furnished, by the physicians of Kansas.

OFFICIAL PROCEEDINGS

FOREWORD TO DELEGATES

Since the agenda of the House of Delegates has increased appreciably due to war and other activities, and time is an important element, it is again imperative that we print all possible reports and that these be read by the delegates preceding the meeting. Therefore, it is hoped that all officers and delegates will be familiar with the contents of the following reports.

Councilors will be elected for the following districts: Fourth, Fifth, Ninth and Eleventh.

The following is the report of the Councilor of the First District:

To: THE HOUSE OF DELEGATES:

(Dr. Randell, Councilor for the First District has submitted a chart covering his district, information for which was compiled from a questionnaire mailed to

	each cour	ity se	cretary	in the	distric	t.)		
				Active				
	Counties	(County	MDs	Service	Society	ings	lems
1.	Marshall		13	13	3	14	Six	No
							Meet'gs	
							a year	
2.	Nemaha		10	9	2	10		Yes—Cult
							other	
							Month	
3.	Brown		7	7	4	11	Yes	Yes-Cult
							One a	
							Month	
4.	Doniphan		6	2	1	2	No	No
5.	Pottawaton	ie	12	10	None	11	No	
	Jackson .			4	1	None	No	'Hell Yes'
	Atchison .			12	7	9	Yes	No
							Once	
							a Mo.	
8.	Jefferson .		9	7.	2	7 ·	No	No
				•			On Call	

The medical profession in district number one has been carrying on well during this World War II. We have had one district meeting. This was held in Hiawatha the evening of March 22. The program was furnished by Drs. John L. Lattimore, Harold Jones and Barrett Nelson. Jackson County has discontinued membership in the Kansas Medical Society for the present. There are cult problems in Brown, Nemaha, and particularly in Jackson County.

Respectfully submitted,

J. W. Randell, M.D., Councilor, First District.

The following is the report of the Councilor of the Second District:

To: THE HOUSE OF DELEGATES:

Due to conditions which have imposed so much work on physicians and made time such a premium, practically all problems in the district have been handled by correspondence.

In general, conditions have gone along quite smoothly throughout the year. A lot of work that has been going on behind the scenes, concerned with future benefits to the profession, will receive more and more emphasis.

> Respectfully submitted, O. W. Davidson, M.D., Councilor, Second District.

The following is the report of the Councilor of the Third District:

TO: THE HOUSE OF DELEGATES:

The embryo of Socialistic Medicine reached maturity and consequently was delivered in June 1943; it has been the problem child for the men at home, its reactions immediately demonstrated that unless very drastic action was taken now, it would with age, be beyond control, thus problems aside from scientific medicine has received the major attention.

The problems that arose during the year were:

- The Soldier-Wife program.
 State legislation.
- 3. Wagner-Murray-Dingell Bill.
 - a. Prepayment insurance.
 - b. Post graduate plans.
- 4. Maintenance of public relations.

On each occasion that the council voted on the subsidized obstetrical program I cast against the proposal.

In compliance with the wishes of the officers and council, arrangements were made with the various societies of the Third District for a visit with each one that gave support (all did save one.) Personal visits were made to discuss all the above problems; closer unity and acceptance of more personal responsibilities was urged; support of the activities of the National Physicians Committee was advocated; financial as well as moral; active participation in the selection of our state and national representatives was requested. It was advised that we had better recognize the fact of the present day tendencies of social changes, which are surely pregnant with dissaster, then meet them with more than an indignation! For, it we don't, someone else will and in all probabilities that someone will be politicians who will leave us in

the rain while they utilize the umbrella taken from the profession. Please avoid complacency!

We were able to secure approximately twelve editorials on the Wagner Bill for the district; we got eight full page newspaper advertisements of the matrix furnished by the N.P.C. and this gave fair coverage for the district; over 500 pamphlets were distributed; there were several talks given to various clubs and organizations in various centers over the area; we now have active in all counties, a Public Relations Committee and this committee has the program in mind, and we expect to hold a meeting of the committees from the nine counties as soon as all candidates have announced and appraisals have been made by the respective county committees, thus securing concerted action. Enthusiastic support has been given to the problems of prepayment insurance and the establishment of a definite post graduate program. A meeting of the district was held and consideration of the post graduate program and prepayment insurance was given by Drs. Jones and Nelson respectively. Considerable time and expense was involved in arranging for this dinner meeting. Attorney Douglas Hudson of Ft. Scott was the after dinner speaker and he performed in a magnificent manner. Drs. Lattimore and Loveland again gave of their time and attended, lending their usual and excellent support to Kansas medicine.

In the interest of the district, the one day meeting in Chicago, of the National Conference on Medical Service and Public Relations, was attended.

At the request of Dr. Cave, the district was surveyed, September 15, 1943, results were as follows:

Population of Third District23	1,060				
Total number of Doctors	155				
Doctors under 60 years of age					
Doctors over 60 years of age					
Total number of hospital beds in district	557				
Per cent of heds continuously occupied	959				

(Note. Report as of March 15, 1944, shows that the number of people per doctor is in excess of 1700, and assumes that all doctors are capable of performing equally.)

The men of the Third District are fully aware of their status and they are firmly united to move along the proper course. I have the conviction that progress has been made and for this gain, I congratulate those responsible for it . . . namely, the profession of the district.

Respectfully submitted,

C. H. Benage, M.D., Councilor, Third District.

The following is the report of the Councilor of the Fourth District:

To: THE HOUSE OF DELEGATES:

As I have only been a Councilor for the past two or three months (succeeding Dr. Philip Morgan now in service) there is not much of a report I can make.

The Lyon County Medical Society still carries on with the regular meetings even though we have lost seven of our leading men. These meetings are attended by men from the surrounding counties even though they have societies of their own. All in all the meetings are of much better quality and better attended than I had anticipated considering war time conditions.

Respectfully submitted,

Frank Foncannon, M.D., Councilor, Fourth District. The following is the report of the Councilor of the Fifth District:

To: THE HOUSE OF DELEGATES:

It has been impossible for your Councilor to visit the component societies in the Fifth District. However, there have been contacts with the various county society officers, and I am able to report at this time that in spite of the depletion of members that the local societies are, without exception, active and alert to the problems which must be faced during this coming year.

It is my belief that there is general agreement among the members of the Fifth District that the program inaugurated looking to the establishment of a permanent post praduate plan should be actively supported. This program to be maintained as a permanent activity directed by the State Medical Society, the State Board of Health, and the University of Kansas for the benefit of the entire medical profession in the state.

The Fifth District is also in full accord with the necessity of working out some type of lay insurance plan to be governed and controlled in a large measure at least by the members of the Kansas Medical Society.

The Fifth District is happy and proud to welcome Dr. Marion Trueheart into the position of President of the Kansas Medical Society.

Respectfully submitted,
J. L. Grove, M.D.
Councilor, Fifth District

The following is the report of the Councilor of the Sixth District:

To: THE HOUSE OF DELEGATES:

Due to the limitations on travel, we have not been able to attend meetings of all the county societies in this district, but have attended several and find a rather surprising amount of activity and interest in several of the county societies. Attendance is good, probably better than average considering the times, and the membership are very much interested and awake to their responsibilities and the problems before the state Society in general. There has been considerable interest in the problems of Blue Cross and prepayment plans for medical services.

The Sixth District meting will be held in Wichita on May 2, 1944, in conjunction with the Sedgwick County Medical Society, at which time presentations will be made by Dr. Nelson, Chairman of the Committee on Medical Economics, in regard to possible pre-payment plans for medical service, and by Dr. H. H. Jones in regard to the Committee on Post Graduate Education.

While the profession as a whole in this district is operating with considerable decrease in numbers and at the same time handling an increased volume of business, it is our opinion that the profession at its present level is still providing satisfactory and adequate medical service in this district.

Respectfully submitted,

Warren F. Bernstorf, M.D.
Councilor, Sixth District

The following is the report of the Councilor of the Seventh District:

To: THE HOUSE OF DELEGATES:

The time of year has again arrived to present to you some notice of the activities of my District, the Seventh, during the past year. It is rather embarrassing to make this report since, as doing my last year's report, I must admit the difficulty of visiting all of the societies in my district. But, during the past year I have had the pleasure and satisfaction on two occasions of attending Clay County Medical meetings, and I wish to inform you that this organization is indeed a live and very active society. They hold their regular scientific meetings, and there is very much interest shown at all times.

Also I arranged and attended a common meeting at Concordia with Cloud, Jewell, Mitchell, Republic and Washington County Societies for the purpose of presenting complete information and knowledge of the new post graduate plan of study, and the contemplated Kansas Medical Society sponsored group insurance plan to care for the surgical, obstetrical and catastrophic cases. These two subjects were presented by the capable chairmen of the state committee. Dr. H. H. Jones of Winfield and Dr. B. A. Nelson of Manhattan. Each of these men has spent much time in preparation of his subject, and were thoroughly conversant with all details, and prepared to answer all questions that arose concerning their subjects. The willingness of these two physicians to attend this meeting was indeed very helpful, and I believe appreciated by all present.

The meeting was very well attended by representatives from all the seven counties in my district. We were entertained very graciously by the Sisters of the St. Joseph Hospital, including a very wonderful dinner given by them. All physicians in attendance were of the opinion that the dinner and entertainment extended us very amply repaid all and any driving incident to their attendance, regardless of any information they receive concerning the contemplated additional activities of the state Society as presented so ably by Drs. Jones and Nelson.

Also in attendance at this meeting was our thoroughly active and most capable and interesting President of the Kansas Medical Society, Dr. J. L. Lattimore, who gave a most enlightening talk. As usual Dr. Lattimore displayed his great enthusiasm and splendid understanding of these new activities contemplated by the state Society.

Dr. Roy Croson, our state Secretary, was also introduced and made several interesting remarks and comments pertaining to these same activities.

After the presentation of their subject matter by Drs. Jones and Nelson, there was much comment and many queries, particularly regarding the pre-payment group insurance plan as advanced by Dr. Nelson, and I am happy to say there were no adverse comments made at this meeting on either plan. In other words, it would seem that we might reasonably hope that the county societies represented at this meeting would probably instruct their delegates at the main meeting to cast favorably ballots on these activities. It seemed to be the unanimous opinion that the pre-payment group insurance plan would fill the general need in our state, which need is becoming more evident daily by the insistenct of groups that feel such type of in-

surance be available to them. By this action of the Kansas Medical Society, it is hoped and confidently believed to be a forward and progressive step in solving any questions concerning the payment of burdensome fees that are unexpectedly imposed particularly upon people of the middle and lower income groups.

Clay County—population 11,400. Has ten physicians practicing there. There are three physicians in the armed forces. In December 1943, Dr. R. J. Morton age 85, died of broncho-pneumonia. Dr. Morton was an honorary member of the Society, having practiced for many years at Green and throughout the country. Clay County's hospital requirements are apparently ample, and are taken care of by the Clay Center Municipal Hospital. The Farm Security Administration plan has not been employed in this county. The local society holds regular scientific meetings the second Wednesday in each month, excepting in July and August. The usual form of program has been a symposium on some important disease with all members participating. Outside speakers are used about once during the year. As stated before this society is absolutely alive and wide awake in every respect. They have 100 per cent society membership of the physicians in their county. Dr. D. O. Jackson of Clay Center and Dr. J. E. Hewitt of Wakefield have moved to other locations during the year. No shortage of physicians.

Cloud County-population 15,000. Has fifteen physicians practicing in the county. There are four physicians in the armed forces. Dr. C. R. Nelson of Jamestown died on October 18, 1943. Hospital facilities are very ample, Concordia having the Concordia and St. Joseph Hospitals. The Farm Security Administration plan has been tried. It does not seem satisfactory, nor is it now needed according to the secretary's report. Cloud County Medical Society has three or four scientific meetings a year, and these meetings are indeed very well attended, and frequently they have outside medical talent as speakers. They have conducted exchange meetings with the physicians in military service at their Internment Camp near Concordia, and these meetings have proved very interesting. They report a society membership of 99.33 per cent. No shortage of physicians reported.

Jewell County—population 10,000. There are nine practicing physicians in the county. There are no physicians in the armed service. Concerning the hospital facilities in Jewell County, they apparently depend upon the not too far distant towns of Concordia, Beloit, Belleville and Superior, Nebraska. The secretary failed to state whether he feels these are adequate or not. The Farm Security Administration plan has been tried for three years, and is not now being employed. The secretary reports that it does seem to be satisfactory on the whole; some of the physicians feel it is not justified because several members of the plan have moved or transferred to other counties. Jewell County Medical Society does not hold regular scientific meetings, but rather depends upon and attend the meetings at Beloit and Concordia, which are usually very fine meetings. Apparently they have nearly all physicians in the county as members of their local society. No shortage of physicians.

Mitchell County—population 8,500. There are ten physicians practicing in the county. There is one physician in the armed service. The hospital facilities

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very satisfactory inded. The Farm Security Administration plan has been tried, but is not employed now. Has been satisfactory to patients and physicians. Regular scientific meetings are held each month, with exception of August, and are highly satisfactory. They obtain outside medical talent for about one-half their meetings, the other half of their meetings they use their own members. They report 100 per cent belong to their society. No shortage of physicians.

Republic County—population 11-12,000. There are eight physicians practicing in the county. There is one physician in the armed service. Apparently the hospital facilities are adequate. They use the Patterson Memorial Hospital at Belleville. The Farm Security Administration plan has been tried for three years; is not now being employed. It has not been entirely satisfactory to either patients or physicians. They hold monthly scientific meetings. All active physicians of the county are members of the local society. No shortage of physicians reported.

Riley County—population 21,668. There are fourteen practicing physicians in the county. There are six physicians in the armed service. The hospital facilities are adequate; Manhattan having the St. Marys, Parkview and the College Hospitals. Farm Security Administration plan has not been tried. Monthly meetings are held, and when possible scientific programs are arranged. In November, 1943, Dr. Hiebert of the Tuberculosis Division of the Kansas State Board of Health gave a talk and lantern discussion before the society on the photofleurographic unit, which had recently been used at the College for faculty and students. All physicians in the county, with the exception of one, belong to the local society. No shortage of physicians reported.

Washington County-population 14,000. There are six physicians practicing in the county. There are two physicians in the armed service. Washington has no hospital in the county, patients are taken care of by Marysville, Concordia and Clay Center hospitals, a distance of twenty-eight to fifty miles. The Farm Security Administration plan has not been tried. Up to the past year they have held regular meetings each month. The secretary reports that during the past year meetings have been called as business arises. The secretary reports that they still have one local osteopath practicing medicine, which causes them some concern. Percentage of physicians belonging to the local society is 100, with the exception of one physician at Haddam. No shortage of physicians reported.

The general condition of my district appears to be in as good and satisfactory condition as last year, and though there are communities wherein physicians are probably overworked, it seems to be the opinion they are capable of handling all the work in a very satisfactory manner.

Respectfully submitted, R. R. Cave, M.D., Councilor, Seventh District.

The following is the report of the Councilor of the Eighth District:

To: THE HOUSE OF DELEGATES:

I have attended the medical meetings in this district as well as I could under existing conditions. I

find them well attended and having good programs. The medical personnel of the Army have been very good about helping with the scientific part of the meetings. We have been very fortunate in having some excellent men.

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A survey of the Eighth District shows the medical needs of the people are being well cared for. Most of the doctors are working pretty hard but seem to be bearing up well.

Locally we have supported and assisted in the training of a Nurses Aide class. They are a great help to our hospital. I hope to attend the state meeting in May.

Respectfully submitted, B. H. Mayer, M.D., Councilor, Eighth District.

The following is the report of the Councilor of the Ninth District:

To: THE HOUSE OF DELEGATES:

During the last year the Ninth District suffered a grave loss in the death of Dr. L. C. Tilden of Oberlin. Dr. Tilden was a very able man and served his community efficiently and unselfishly for fifty years.

Each community in the district is receiving normal medical care, as compared to the pre-war period.

Cheyenne County is to have a new county hospital after the war. At a special election held during the past year, this proposition carried by a vote of two to one. Rawlins County has successfully circulated petitions to decide the question of a county hospital.

The State Sanitorium for Tuberculosis at Norton is carrying on an efficient and progressive program for the people of the state.

The society of this district held one meeting, which was well attended.

Respectfully submitted,

Haddon Peck, M.D.

Councilor, Ninth District.

The following is the report of the Councilor of the Tenth District:

TO: THE HOUSE OF DELEGATES:

The war effort continues to demand all the time of the doctors in this district and they are giving themselves to the utmost. No one seeking medical relief has been neglected. Meetings of the societies have suffered on this account but the attendance was, considering the conditions, satisfactory.

Co-operation on all problems was given freely. I wish to take this opportunity to thank each individual in the Tenth District for their consideration.

Respectfully submitted,

Otto A. Hennerich, M.D., Councilor, Tenth District.

The following is the report of the Councilor of the Eleventh District:

To: THE HOUSE OF DELEGATES:

All requested reports have been sent in on time. Because of the scarcity of doctors and resultant extra load on those remaining, this district has held few meetings. Two out of three called meetings were attended.

No visitation by the councilor has been made although the presidents of each society have been contacted. No community has suffered from the lack of medical care and the care of the sick has been well handled at considerable sacrifice.

Respectfully submitted, J. R. Campbell, M.D., Councilor, Eleventh District.

The following is the report of the Councilor of the Twelfth District:

To: THE HOUSE OF DELEGATES:

The Twelfth Councilor District has been very inactive during the last year.

We have attempted to have one meeting, but owing to the weather conditions, it was impossible for out of town doctors to attend. However, we hope to have a meeting before the state meeting in May.

About all we have to report are things we don't like. We lost several doctors to the Army, leaving us a large scope of territory without doctors. For every doctor that moves out there is an osteopath moves in.

I realize this is a very short report but we have had few activities as a society.

Respectfully submitted,

G. R. Hastings, M.D. Councilor, Twelfth District

The following is the report of the Defense Board: To: The House of Delegates:

A long cherished ambition of the Defense Board was achieved last year. One which is unique so far as we know. It was not necessary for us to actively defend a single member of our Society against a malpractice suit. We hasten to add that there were cases in the state but the members involved were so well insured in companies selling liability insurance that our active participation was not necessary.

Other factors which we believe helped establish this record are:

I. Caution on the part of our members in making statements admitting faults.

II. The avoidance of all derogatory remarks about the work of colleaugues.

III. Improvement of records of cases. This has been helped by standardization of hospitals.

IV. Improved care of the sick and injured and apparently more willingness to call council when such is even remotely indicated. This is very important.

V. Better understanding of physicians of their legal responsibility to their patients.

We hope that the above will serve as admonition to our members and that vigilance in these matters will not continue but be increased. We would like to suggest a few other points which should be kept in mind. Certainly we are all far too busy now to have to waste time defending ourselves or in dissipating our nervous energy in such a barren pursuit when, "An ounce of prevention is worth a pound of cure."

I. Give every patient careful attention and insist upon efficiency on the part of assistant nurses and technicians.

II. Check frequently equipment and appliances attached to patients. Remove and replace if there is any evidence of trouble.

III. Never admit to a patient that liability insurance will cover mismanagement. This weakens our own character of responsibility and is certainly unfair to the insurance carrier as well as to our Society.

IV. Careful evaluation to the patient or his family or both concerning the prognosis, particularly where there may be any permanent deformity or limitation of function or anything more serious than these two factors. Take time to explain frankly what is to be expected.

These are only some of the factors which we believe will help to further improve our record. The better our experience in this regard over a period of years the lower the rate we may expect from our carriers.

Thanking you all for your help in improving our record and in the hope of future betterment of this situation this report is respectfully submitted.

H. N. Tihen, M.D. L. S. Nelson, M.D., Defense Board.

The following report was submitted by George E. Milbank, M.D., of Wichita, Chairman of the Committee on Allied Groups to Medical Practice:

To: THE HOUSE OF DELEGATES:

Due to gas rationing and the shortage of physicians, and the lack of new business to come before the Committee on Allied Groups to Medical Practice, we have had no formal meeting of the committee this year.

We again wish to point out the value of a medical examiner law as contrasted to the Kansas coroner law and to recommend efforts to have this change made.

The inequities in the Kansas Crippled Children's Law and its interpretation by the Crippled Children's Commission, a condition, which we reported as of last year is still unchanged, and further efforts to improve this situation should be continued.

Our present cosmetology law which gives rather broad powers to cosmetologists should be changed by the legislature, if and when it seems advisable to do so.

We believe that these are the principal points needing further work as of this time and we would recommend further consideration of these.

The following is the report submitted by V. E. Chesky, M.D., of Halstead, Chairman of the Committee on Appendicitis:

TO: THE HOUSE OF DELEGATES:

In regard to the report of the Committee on Appendicitis. There has been no meeting of the committee and there has been nothing written. Therefore, there is nothing to report. I am sure that I, personally, am tickled to death if I can get my work done every day, which I usually do not do.

The following is the report submitted by H. M. Glover, M.D., of Newton, Chairman of the Committee on Automobile Accidents and Fractures:

To: THE HOUSE OF DELEGATES:

The Committee on Automobile Accidents and Fractures has held no meetings during the past year due to transportation curtailment, and also due to the fact

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that because of less automobile travel there has been a marked decrease in the number of accidents and fractures due to accidents.

The following report was submitted by C. Omer West, M.D., of Kansas City, Chairman of the Committee on Auxiliary.

To: THE HOUSE OF DELEGATES:

The Auxiliary Advisory Committee is happy to report that the Auxiliary has had a most active year. They have been pinch-hitting in many activities such as, aiding the Red Cross in their work, active in the hospitals as assistants and many acting as office assistants for their husbands.

The atendance at meetings has been reduced but their various activities have increased. Many of the auxiliaries have had speakers to present the Murray-Wagner-Dingell Bill to the lay public and this project has been a most worthwhile activity and much good has been accomplished. They have also continued with their public relation meetings with fine success. Through these meetings the Auxiliary has been able to contact the lay public giving them medical information that is valuable to the medical profession.

We wish to commend Mrs. Ernest E. Tippen on her fine year as President; it has been a joy to work with her and her various committees; they have done a nice job and we thank them.

There is a growing recognition of the Auxiliary by the State Medical Society of Kansas.

The following is the report submitted by A. W. Fegtly, M.D., of Wichita, Chairman of the Committee on Constitution and Rules:

To: THE HOUSE OF DELEGATES:

As a result of a meeting of this committee held in Wichita at the 1942 session and followed up by corespondence during the current year your committee presents several amendments to our present Constitution and By-Laws. The committee was unanimous in recommending the adoption of all with the exception of (2) the amendment providing for Associate Membership in the State Society, and (3) the restriction placed on the length of tenure of any single member as Representative to the House of Delegates of the National American Medical Association. These two amendments should be subject to careful consideration before adoption. Each member has or should have copies of the revision sent out in 1942 for comparison with the suggested amendments so for conservation of space all the original sections are not here given but are explained in brief. For purposes of discussion and consideration they are numbered.

(1) AMENDMENT TO BY-LAWS, CHAPTER 1, Section 4.

The original section provides for honorary membership in the state Society upon recommendation of the component societies. To this section paragraph 2 should be added as follows:

"Honorary members having qualifications required by the Constitution of the A.M.A. may be recommended for Affiliate Fellowship in the A.M.A. by vote of the House of Delegates."

(2) AMENDMENT TO BY-LAWS, CHAPTER 1, Section 5 to be added.

This new addition to the By-Laws could be considered and adopted as a whole or certain portions could be deleted.

"Individuals not having the degree of Doctor of Medicine, interested in the science or in scientific research, or whose field of work is allied to the medical profession may become Associate Members of this Society by a majority vote of the House of Delegates at any regular session to which application is made.

Applicants for Associate Membership shall state name, age, nationality, membership in any scientific society or position held in allied work, and the particular work of interest to the applicant, and should be addressed to the House of Delegates.

Officers of the United States Army, Navy, Marine Corps, or Public Health Service whose legal residence is not in the state of Kansas, but who are temporarily stationed within the state of Kansas, or whose work included the state of Kansas, may in the same manner become Associate Members of this Society without affecting their standing in any state society to which they already belong.

Associate members shall be entitled to attend and participate in all regular scientific meetings upon registration and payment of an annual fee of \$5.00 but shall have no vote in the conduct of the business of the Society, nor be eligible to hold office in the Society."

(3) AMENDMENT TO BY-LAWS, CHAPTER V, House of Delegates, Section 17.

The wording of the body of this section has been changed somewhat in order to clarify it and the final clause of limitation of tenure of office has been added.

"Representatives to the House of Delegates of the American Medical Association shall be certified to each annual meeting of that body according to the Constitution and By-Laws of that association, and shall be selected in the following manner; One-half the number of delegates permitted this Society for two year terms of office shall be selected annually as Delegates-Elect, whose term shall begin with the annual session of the American Medical Association of the year succeeding their election. NO MEMBER MAY BE ELECTED TO SERVE MORE THAN THREE SUCCESSIVE TWO-YEAR TERMS AS DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION."

(4) AMENDMENT TO BY-LAWS, CHAPTER V, Section 8.

The order of business as listed is modified to conform to the plan of stream-lining the reports of committees at the first session of the House, and giving a more definite order of business for the final meeting.

"The official order of business for the first session of the House of Delegates, unless otherwise ordered by a two-thirds vote of the Delegates present, shall be:

- 1. Registration of Delegates and ex-officio members of the House and visitors.
 - 2. Call to order by the President.
 - 3. Reading of the minutes of the last meeting.
- 4. Announcement of the number of Delegates and ex-officio members registered and the presence of a quorum.
- 5. Report of Reference Committee with summarized data on reports of:
 - a. Councilors
 - b. Standing Committees
 - c. Special Committees
 - d. Resoluations submitted

- 6. Report of Defense Board.
- 7. Report of Editorial Board.
- 8. Report of Executive Secretary.
- 9. Report of Constitutional Secretary.
- 10. Report of Treasurer.
- 11. Report of A.M.A. Delegates.
- 12. Message of the President.
- 13. Message of the President-Elect.
- 14. Unfinished business.
- 15. New business.
- 16. Announcements.
- 17. Adjournment.

The official order of business for the last meeting of the House of Delegates at each annual session shall be:

- 1. Registration and seating of Delegates, ex-officio members and visitors.
 - 2. Call to order by President.
- 3. Report of secondary meeting of Reference Committee.
 - 4. Unfinished business.
- 5. New Business (except for authorization of proper bills, must be authorized by consent of twothirds majority of Delegates to the session.)
 - 6. Election of officers:

President Elect

First Vice President

Second Vice President

Constitutional Secretary

Treasurer

Delegate-Elect to A.M.A.

- 7. Election of Councilors for expired terms by caucus of Delegates present from the respective districts.
- 8. Announcement of Councilor elected and meeting place of the Council.
 - 9. Installation of the new President.
 - 10. Adjournment.

(5) AMENDMENT TO BY-LAWS, CHAPTER XI-Committees-Section 1, 2, and 3.

Changes in this chapter are made to conform to the plan of the use of the Reference Committee to expedite the annual meetings, and also to include three of the present special committees in the list of standing committees.

Section 1, shall be amended to read as follows:

"Regularly appointed committees of this Society shall be of three classes:

a. Standing Committee whose work continues from year to year. These are: (For brevity the existing list of committees is omitted since none have been removed and only the committees added are named.)

Committee on Study of Heart Disease

Committee on Insurance and Industrial Medicine Committee on Conservation of Hearing.

- b. Special Reference Committee or Committee on Reports of Councilors, Committees, and other reports deemed by the President subject to condensation.
 - c. Special or temporary committees."

Section 2: Shall be amended by the addition of the

following paragraph:

"A special reference committee to consist of at least three members shall be appointed two weeks before each annual session."

Section 3: Shall be amended to read as follows:-"Each standing committee or special committee shall submit to the executive secretary a written report in

duplicate, addressed to the House of Delegates, not later than six weeks before each annual session, the same to be printed in the Journal or a handbook for distribution to the membership for information and consideration prior to the annual meeting, and shall submit such aditional reports as the House of Delegates or the Council may require.

The special reference committee shall study the reports of standing committees, special committees, Councilors, and other reports deemed by the President as worthy of condensation, as well as any resolutions to be offered to the House of Delegates, and submit concise and summarized statement of the work of the year as shown in the individual reports, before individual or collective adoption by the House of Delegates as a part of the record. Resolutions presented shall be duly considered and recommendations made for their adoption or rejection. The committee report shall be submitted at the first meeting of the House, and if deferred action on such recommendations is deemed advisable, the committee shall hold subsequent open meetings for hearings on the subject before final action is taken at the last regular meeting of the House of Delegates.'

(6.) The following three amendments delineate the duties of the new standing committees.

AMENDMENT TO BY-LAWS, CHAPTER XI, Section 28 (to be added).

"The Committee on the Study of Heart Disease shall consist of at least five members. It shall be the duty of this committee to conduct study and research on the subject of diseases of the heart, and circulatory diseases affecting or originating from the heart, and to disseminate information on these subjects to the component organization of this Society, to the medical professiion in general and to the public when lay education is desirable. A portion of its retiring members, and whenever practical, the retiring chairman, shall be included in its membership."

Section 29 (to be added.)

"The Committee on Insurance and Industrial Medicine shall be composed of at least five members. It shall be the duty of this committee to study and become intimately acquainted with every and all movements agitated, proposed or attempted to enact or be enacted, that has for its object either secret or avowed the providing of social ,commercial, or industrial medical insurance for the public, civil, or commercial employees of persons, companies, or corporations, or for the providing of medical or surgical care to a group or groups of individuals, either collectively or singly, or which in any manner affects the economic or financial status of the members of this Society, to represent this Society in efforts to secure greater co-operation and a greater mutual understanding between medical men and employers of labor or their insurance carriers concerning the rendition of professional services in industrial cases and the amount and character of compensation therefore; to devise and advise whenever intelligent action on the part of this Society is desirable upon these questions, and to report in writing its findings, recommendations, and information obtained, to this Society or to the House of Delegates. A portion of its retiring members, and whenever practical the retiring chairman, shall be included in its membership."

Section 31 (to be added)

"The Committee on Conservation of Hearing shall be composed of at least five members. It shall be the duty of this committee to conduct study and research on the subject of conservation of hearing, and diseases affecting the otic organs and to disseminate information on these subjects to the component organizations of this Society, to the medical profession in general, and to the public whenever lay education is desirable. A portion of its members, including the retiring chairman, whenever practical shall be included in its membership."

These amendments are presented for your consideration at the first meeting of the House of Delegates in Topeka on May 10.

Chapter XV—Amendments of the By-Laws provides as follows:—

"These By-Laws may be amended at any annual session by a majority vote of all the Delegates present at that session after the amendment has lain on the table for one day."

Respectfully submitted, A. W. Fegtly, M.D. Chairman, Committee on Constitution and Rules.

The following report was submitted by Frank A. Trump, M.D., of Ottawa, Chairman of the Committee on Control of Tuberculosis:

To: THE HOUSE OF DELEGATES:

The Committee on Control of Tuberculosis held two meetings at the Hotel Jayhawk in Topeka. The first on July 18, 1943 and the second on March 26, 1944. Committee activities in the year have been greatly limited by war restriction as to travel.

The committee reports with approval the activity of the State Board of Health through its Division of Tuberculosis Control and the operation of the photofluorographic unit which in 1943 received the endorsement of the committee and the Kansas Medical Society. Changes in policy of the State Board of Health concerning the training of full time health officers to read x-ray pictures was approved.

The committee commends the work of the Kansas Tuberculosis and Health Association which has demonstrated increased activity in case-finding of early tuberculosis with the employment of Dr. Seth L. Cox. The committee welcomes cooperation of medical societies throughout the state; while desiring to give special mention to enthusiastic new work in the southern Kansas counties—Montgomery, Labette, Cherokee—it can also mention many others in which work has long been well established and several new counties such as Jackson, Barton, Rush and Rooks.

Kansas Medical Society members should give publicity to the fact that deaths in 1943 from all forms of tuberculosis were less than in any year of our statistical history, being a total of 363. This gives Kansas a death rate in the close neighborhood of twenty per 100,000 citizens. The committee calls attention to the offer of the Kansas Tuberculosis and Health Association made on behalf and with the cooperation of the physicians of Kansas that any citizen desiring definite assurance as to personal safety from tuberculosis may obtain such service.

Concerning the problem of providing more beds to

relieve the waiting list at Norton, the committee approved the action of the Sanatorium Board of Control in taking over Hillcrest as an experiment since it seems to be the quickest way to provide some relief, until such time as the legislature can and will build another institution that will really be adequate.

Throughout the year material in reference to tuberculosis control has appeared in each issue of the Journal.

The following report was submitted by C. C. Nesselrode, M.D., of Kansas City, Chairman of the Committee on Control of Cancer:

To: THE HOUSE OF DELEGATES:

This committee is unable to report as active a program as we have carried on in other years as far as professional education is concerned.

The program for lay education has continued with unabating interest and success. The lay educational program is carried forward by the Women's Field Army of which Mrs. Daisy Johntz of Abilene is the State Commander. The past year has been their most successful year, measured by number of membership enrollments, the amount of money collected and the number of meetings held.

The present year, 1944, professes to be even a better year than 1943. There continues to be very close cooperation between this Cancer Committee and the activities of the Women's Field Army.

The Women's Field Army deserves the credit for the excellent manner in which the lay educational program has been carried forward. While they have frequently sought advice, they have done the work themselves. It is with a feeling of satisfaction that the committee acknowledges this and congratulates them on their excellent success.

The following report was submitted by H. L. Chambers, M.D., of Lawrence, Chairman of the Committee on Endowment:

To: THE HOUSE OF DELEGATES:

Because of the war effort and the use of all resources to make it succeed, this has been an unfavorable year to solicit endowment funds or other material.

The pressure to conserve gasoline and rubber along with the extreme preoccupation of the members of the committee with their private and personal professional responsibilities made it seem unwise to call any meeting, so none was called. Should any promising prospect appear, we stand ready to attend to it.

The following is the report submitted by Charles Rombold, M.D., of Wichita, Chairman of the Committee on Industrial Medicine:

To: THE HOUSE OF DELEGATES:

The Committee on Industrial Medicine has not had a meeting all year. There have been very few factors that appeared to be of any imoprtance with the exception of an endorsement of the legislature for the inclusion of industrial illnesses as well as industrial accidents in the Industrial Code.

Insofar as no legislature is to meet this year, it is but wise that this suggestion should be handed on to the next Industrial Health Committee for their consideration. The following is the report submitted by C. C. Hawke, M.D., of Winfield, Chairman of the Committee on Legal Medicine:

To: THE HOUSE OF DELEGATES:

Your Committee on Legal Medicine has not had an opportunity to meet during the past year due to difficulties of transportation. Your chairman visited the headquarters of the legal department of the American Medical Association in Chicago and had a lengthy conversation with the director and much valuable information was gained from that office.

The National Association is cooperating with the American Law Institute on national problems affecting both the legal and medical profession jointly, such as "Physician-patient privileges," "Expert and opinion evidence" and the coroner laws in the United States. These three points are apparently uppermost in the minds of both professions at this time and should be of interest to every member of our profession.

Your chairman has been in communication with Mr. George Templar of Arkansas City, who is the legal cochairman of our committee, and we both felt that a joint meeting was not feasible this year. It was our purpose to have some eminent legal authority address the state medical meeting this year, but due to the limited amount of available time the space could not be granted.

Your committee feels that the coroner question is one of the most pressing points of issue in the state of Kansas and that the Legal Medicine Committee of the ensuing year should devote considerable attention to the study of this point.

We feel that there is an important work for this committee and that its function should be continued.

The following is the report submitted by R. R. Cave, M.D., of Manhattan, Chairman of the Committe on Location and Medical Distribution:

To: THE HOUSE OF DELEGATES:

In supplying an annual report of the activities of the Location and Medical Distribution Committee of which I am chairman, I feel that our accomplishments are very little indeed. However, I am not at all surprised since I have had the feeling on my first notification of my appointment to this committee that we would achieve very few results. The reason being that we have no physicians to distribute, and therefore could not possibly do a great deal. I have corresponded with Dean Wahl of the Univesity and Dr. J. F. Hassig concerning available physicians without any particular success.

Your committee held one meeting in Manhattan on September 2, 1943. Those present were, Drs. Butler, Butcher, Fleckenstein, Schenck, Wrightman and myself. I wish to commend the members of this committee who attended this meeting since some of them drove many miles to get here and regret our accomplishments did not justify their long trip.

We had corresponded with the councilors of the state Society prior to this meeting requesting that they inform us concerning the conditions existing in their respective districts as regards needs for physicians. Requests were made for physicians from the following places; Holyrood needed one physician; Lebo and Hartford each needed a physician; Altamont, Edna,

Oswego and Mound Valley each needed a physician; Hill City probably needed a physician; Medicine Lodge probably needed a physician, and these were the requests which seemed quite modest to the committee. Most of the councilors were of the opinion that their district was quite satisfactorily taken care of.

March 21, 1944 I received a wire from G. W. Wright, M.D., of Neodesha, requesting information on a town of 5,000 or better with hospital facilities where a general practitioner might locate. I had nothing to offer other than I gave him a list of the locations mentioned herein.

It is the chairman's opinion that this work probably could be better handled at the central office in Topeka, as it is further my opinion that most all inquiries will go into that office. However, I assure you that if you so decide, your committee will do anything possible to carry on in this, or any other capacity.

The following report was submitted by Ray A. West, M.D., of Wichita, Chairman of the Committee on Maternal Welfare:

To: THE HOUSE OF DELEGATES:

The activities of this committee were greatly curtailed during the year on account of gasoline rationing and the greatly increased burden on all of the members due to the emergency. One meeting was held in Topeka, Thursday, September 23, jointly with the Committee on Child Welfare, for the purpose of assisting the State Board of Health and the council in deciding problems relative to the emergency maternity and infant care program.

The Maternal Welfare Committee also has continued to issue periodically desk cards on the "Minimum Standards of Obstetrical Care," for the general profession throughout the state.

The following is the report submitted by Barrett A. Nelson, M.D., of Manhattan, Chairman of the Committee on Medical Economics:

To: THE HOUSE OF DELEGATES:

This year has been marked by resounding events in the field of medical economics. The most startling are the reverberations emanating from the nefarious Wagner-Murray-Dingell Bill, now reliably reported to have met a timely death in committees of the Senate and House.

But the issue is still much alive, and our committee studies convince us that demands for easing costs of serious illness must be met. The chairman of this committee attended the Chicago meeting of the Medical Service Plans Council and an extensive, exhaustive study has been made of the whole problem. Meetings have been held with society groups over the state for discussion of the subject. Prepayment plans now successfully operating in many states under medical society control are offered as the most effective answer which will retain control with those who furnish the medical service. A tentative medical service plan is, therefore, to be presented to the House of Delegates with recommendations for adoption at the forthcoming annual session.

Kansas medicine has admirably met the problem of indigent care. Method varies somewhat in different counties but those in effect in Riley and Shawnee counties are typical. Widespread national interest is shown as in the article by R. W. Callahan, Executive Secretary for the Shawnee County Medical Society requested for publication in the New York City Medical Journal.

Enthusiastic approval is general for the hospital service plan now functioning through the Kansas Hospital Service Association, our state "Blue Cross" organization. A very large and rapidly growing membership of participating hospitals and subscribing members reports full satisfaction with the results. The form of organization meets with our complete approval as there is no encroachment into fields outside legitimate hospital practice, and administration has been uniformly effective, efficient and co-operative. Much credit is due the Board of Directors which, incidentally, includes six members of the medical profession.

The following is the report submitted by Fred J. McEwen, M.D., of Wichita, Chairman of the Committee on Medical Schools:

TO THE HOUSE OF DELEGATES:

During the past year the Committee on Medical Schools has held no meeting due to the shortage of time during the present emergency. Many of the problems in relationship to the Medical School are also marking time.

Dean H. R. Wahl has submitted a complete report on the activities of the Medical School, which is printed below.

The following is the report submitted by Dean H. R. Wahl of the University of Kansas School of Medicine on the Medical School for 1943 to 1944:

TO THE HOUSE OF DELEGATES:

A year ago last winter a fire broke out in the temporary quarters provided for the Anatomy Department of the University of Kansas School of Medicine at Lawrence and destroyed this building. An appropriation of \$85,000 was obtained from the Legislature to replace the equipment and remodel Haworth Hall (old Geology Building) for the future use of the Medical School Departments. A short time prior to this fire the Department of Physiology was removed from the Administration Building to Haworth Hall in order to provide accommodations for a large unit of Navy trainees.

The Geology Department which formerly occupied Haworth Hall is to receive quarters in the new Mineral Resources building which was recently completed. The Mineral Resources building is now, however, being occupied by the Army trainees in various divisions of the University and probably will provide quarters for the Geology Department until the war is over. Up until a month ago as many as 700 trainees belonging to the Army Specialized Training Program were housed in this building.

Following the fire which destroyed the quarters of the Anatomy Department, temporary facilities were made in Snow Hall and some of the material was quartered in the basement of the new Mineral Resources building during the past year. The south portion of Haworth Hall was remodeled and provisions made to provide permanent quarters for the Anatomy

Department. The department moved into these new quarters on the first of March and has better facilities now than it has ever had. It occupies three floors; in the basement is the preparation room, offices, and quarters for storage of cadavers. On the first floor are the dissecting rooms and on the second floor is microscopic anatomy. The quarters are of modern, fire-proof construction. Though at present somewhat cramped, it is hoped that when the Geology Department moves out into the new Mineral Resources building that the balance of Haworth Hall will be remodeled to provide quarters for all of the medical sciences at Lawrence, except bacteriology, and in that way for the first time bring the preclinical sciences of the Medical School together in one building and give them modern relatively permanent quarters.

The Medical School has cooperated with the University Extension Division in providing post graduate clinical and extension courses in chest diseases, another one in venereal diseases, and a third one in disease of the heart and cardiovascular system during the current year. These courses were given by the Extension Division with the assistance of the faculty of the University of Kansas Medical School.

The main change in the Medical School during the past year has been the appearance of a considerable number of its students in the uniform of either the Army or Navy. Statistics below will give the actual number of members of the armed services enrolled in classes of the school. Over four-fifths of the students in the school are members of the Army or Navy Training Program.

Total number of students enrolled in the

MILITARY STATUS OF MEDICAL STUDENTS

Classification Army Navy Civilian Women

Freshman 21 32 21* 6

Sophomore 44 20 13* 4

Sophomore 44 20 13* 4
Junior 40 23 11 6
Senior 45 25 8 8

* Hold commissions

The first of the accelerated group of classes graduated on the 31 of January of this year. In this class there were forty-four students in the Army and twenty-six in the Navy, leaving twelve men in the civilian group of whom one was on the Navy's inactive list. The remaining eleven civilian students were either over age for the training programs or physically disqualified for military service. Ten members of the graduating class took internships in the Navy.

Another change in the Medical School is the development of the Cadet Nursing Program in accordance with the recent Federal Program of increasing the number of student nurses. There are at present 120 girls enrolled in our School of Nursing, and ninety-one girls from this group are enrolled in the Cadet Nursing Corps. We had sixteen nurses graduate in January.

The Medical School has gone into the regular ac-

celerated program of admitting a class every nine months, the first class entering on this program on May 24, 1943. A class, as noted above, graduated on January 31, 1944. The next class was admitted on March 6, 1944, and another will enter on November 6, 1944. The next graduating class will be on October 30, 1944. With this accelerated program the students will complete their regular medical course in three calendar years instead of four years as heretofore. Each year will consist of forty-eight weeks with four weeks allowed for vacation and furlough. The regular academic year in school is increased from thirty-three to thirty-six weeks so that the students really get more instruction in the three calendar years than in the prewar program of a four year course. The school has been given complete freedom in the giving of coursese, the only regulation is that they complete the course in three calendar years and add a few minor courses in war medicine with addition of one to two hours of military instruction by the Commanding Officer of the local units. It should be emphasized that no pressure is being made upon this school as to its courses or personnel of the instructors. The faculty is allowed complete freedom as to instruction to be given to the medical students.

About 140 men are now on active duty from the faculty, and over ninety members of the faculty are enrolled in either the Army or Navy, and these comprise most of the younger group. There are less than fifteen men at present on the faculty who are under forty, and these have been designated as essential for the teaching of the medical students.

It should also be noted that the Evacuation Unit 77 developed from the Medical School was called into active service in May, 1942. They were transferred to Ft. Leonard Wood where they were engaged in preliminary training until August when they were sent directly into the European field of operation, and they entered Oran in the invasion of North Africa. This Unit was actively engaged throughout the Tunisian campaign; in fact, at one time they were reported to have been captured at the Kassarine Pass, however, they were in this area but were not captured. From Tunisia the Unit was transferred to Sicily and actively engaged in the combat zone in both North Africa and Sicily. From Sicily they were transferred back to England presumably to take part in the European Invasion that was pending some time in 1944. No casualty has been reported for members of this Unit other than an accidental injury to the arm of Dr. F. A. Carmichael who has returned to this country to recuperate, but he has recently returned to active duty.

The Medical School recently received several contributions towards the developing of research activity; one of these being approximately \$800 from the Kate Stephens Fund which is to be used in the care of indigent children in the Pediatrics Department. Dr. E. J. Curran recently presented the Medical School with a gift of \$10,000 for the development of research work and a fellowship in the Department of Ophthalmology; Dr. O. R. Withers presented \$3,000 for the development of allergy in the Department of Medicine; and Dr. Earl Padgett donated \$7,500 for the development of Plastic Surgery in the Medical School.

The Medical School has incurred one of its most serious losses in the recent death of Dr. C. B. Francisco. Dr. Francisco had been a tower of strength in the development of the Medical School and the teaching given in his field as well as very valuable services he has rendered to the State in combating poliomyelitis. He was especially interested in the students having invited each senior class for many years out to his lovely home. The students themselves initiated a program for a Memorial to him, and this has been supplemented by the faculty, patients, and friends of Dr. Francisco in addition to his classmates in the class of 1907. A program consisting of a suitable memorial, preferably a Student Union Building, has been initiated with a drive for funds with Dr. Galen Tice as chairman. The goal is for a Student Union Building to be erected as a memorial to Dr. Francisco costing \$200,000; thus far \$7,000 has been collected, and the donatiions are continually coming in. While it is questionable whether this program will provide this large amount of money, it will form at least a large nucleus for such a much needed unit. Contributions towards this program are being made to the University of Kansas Endowment Association designated for the Francisco Memorial.

The following is the report submitted by Clyde O. Meridith, Jr., M.D., of Emporia, Chairman of the Committee on the Medical Assistants Society:

TO THE HOUSE OF DELEGATES:

There has been no meeting of the committee during the year. We would like to report that the Medical Assistants Society has been active during the year. There are eighteen organized and active local societies affiliated with the state group and about 150 paid up memberships.

In November, 1943, the society, thru its Executive Council, took \$100 from its general fund and \$150 donations from local societies and purchased furnishings for a sunparlor in the Winter General Hospital in Topeka.

In December the Executive Council met in Hutchinson and made plans for a possible state meeting in 1944. In February the President and Executive Council of the Sedgwick County Medical Assistants Society met and presented to the state group an invitation to hold the 1944 meeting of the society in Wichita on May 12.

The Medical Assistants Society of Kansas is a young organization and a very valuable one. It has attracted national attention. Your committee urges all members of the Kansas Medical Society to see that their assistants become members of the society and that they provide the opportunity and encouragement to them to attend the May 12 meeting in Wichita.

The following is the report of the Committee on Medical History:

TO THE HOUSE OF DELEGATES:

The President, Dr. Lattimore, in appointing the committee, emphasized the fact that our Society has few historical records. The idea of assembling a history of Kansas medicine and of our Society is an excellent one. The Kansas Medical Society is now almost 100 years old and unless we begin soon the work of collecting historical material, early physicians and those associated with pioneer men will be gone and valuable data will be lost, most of it irrevocably.



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DIAPHRAGM INTRODUCER

1. Procedure: The gathering and organizing of medical history requires careful planning. As a preliminary step, to explore possibilities and get an idea of what the task is, your committee sent out letters to some of the outstanding members of the Society. These letters asked for suggestions on two main topics: (1) the best person to make a continuous historical study of our Society; and also any names of persons especially qualified to serve on a semi-permanent and continuous committee; and (2) other immediate feasible activities for the Committee on Medical History.

Of the thirty or more physicians to whom letters were sent, replies came from about twenty. Many valuable and practical suggestions were made. These have been studied and outlined below.

II. Personnel: Various persons were suggested by name for the work of medical historian. One member suggested a paid secretary, the widow of a doctor, or some other well qualified individual, to do historical research. Another thought a full time secretary with some library training to help in uncovering material would be the proper historian. Still another suggestion was to employ some person in Topeka, who would have ready access to the central office files. Another member approved the selection of an older man because "the 'old men' made the early history and can recall it and set it down," with the aid of a younger man to do the leg work of interviewing oldsters and collecting later material, including pictures of



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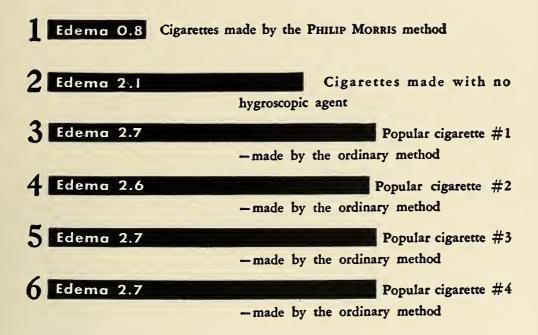
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all physicians.

III. Function: Members varied in their idea of just what the function of such a compilation should be. One person thought the history should be an all-inclusive one. The historian should file and preserve all medical programs, including those outside Kansas on which Kansas physicians appear. He should keep a clipping bureau of notices about Kansas doctors of medicine everywhere. He should preserve and edit proceedings, reports, and actions of all bodies such as the Board of Examination and Registration, the annual registration; all proposed legislation, discussion of bills, and enactment of laws; all reports and publications of the State Board of Health; and all doings of the Red Cross, especially their teaching courses.

One member thought the historian should include all hospital and nurses' association reports; magazine and newspaper comment on new drugs and new medical procedures; the transactions of groups such as the Women's Auxiliary and the lay groups aiding with education in cancer and tuberculosis. He even mentioned collecting material about folklore medicine, household remedies, and quackery; reminding us that Douglas county was the birthplace of osteopathy; and that Christian Science, magnetic healing, and many other 'ism' cults have flourished or died in Kansas.

The suggestion was made that two pages of the State Medical Journal be devoted each month to medical history, including records of meetings and biographies of renowned members, both living and dead, with, when possible, a full page picture on the opposite page.

Another suggestion was that the Society, or its committee, plan to gather information immediately from every county society concerning early medical conditions and history, from pioneer physicians and laymen in their areas. A collection of early medical historical material from belongings of early doctors could be made.

Another member thought the especial task of the committee might be to devise a method of filing records, both past and present, and then turn over the project to a paid historian.

IV. Material: Certain historical material already at hand, or easily available, is to be noted;

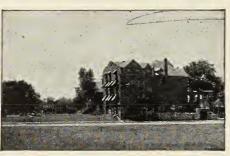
- 1. One or two papers on early medical history are now filed with the Sedgwick County Medical Society. Copies of these should be made for the committee's files.
- 2. A Dr. Crawford was mentioned, who some time ago practiced for twenty-five years in Salina and upon his departure left a good deal of equipment with Dr. Brittain, also of Salina. This material should be gathered up and made available to the committee.
- 3. An article on the "History of the Kansas Medical Society," by Dr. O. D. Walker, published in the Journal of June, 1916. The article was Dr. Walker's presidential address for that year. This article has been called "the best resume of early (Kansas) history ever compiled."

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4. An article by Dr. W. L. Warriner, of Topeka, on the history of the Shawnee County Medical Society.

5. The publication sponsored by the Kansas State Nurses' Association, "Lamps on the Prairie, A History of Nursing in Kansas" 1942, contains an excellent compilation of much source material. This book, made possible by the Work Progress Administration, covers completely the history of nursing in Kansas, beginning with Coronado, who in 1541 was "attended by his own physician and surgeon," through the Lewis and Clark expedition of 1804 and the work of early missionary doctors, down to the present. Chapter V and VI are of especial value to physicians.

6. A clipping from a Lawrence paper was sent in by a member; this cites the account book and partial diary of Hiram Clark, one of the early physicians in Lawrence, now in the possession of Mrs. E. M. Owen, worker in the Douglas County Historical Society. This clipping gives a valuable lead to the kind of material the Society will need for medical history and shows how members can help by sending in similar the society of the sending in similar the society.

lar clippings from their areas.

7. Notation was mde of the recent death of Dr. A. J. Anderson, of Lawrence, who joined his father in practice there in 1886. Mrs. Anderson, the widow, lives in Lawrence and has a great deal of material from both her husband's and her father-in-law's practice.

8. Your chairman undertook a brief investigation of how much medical material the Kansas State Historical Society has. Through the courtesy of Mr. Kirke Mechen, secretary, and the help of Miss Helen McFarland, librarian, and Miss Edith Smelzer, curator, we made a birdseye survey. Admirably cataloged is extensive material on Kansas medicine in the library.

Cross references are full, and a cursory examination revealed such examples as:

a. Complete files of:

The Leavenworth Medical Herald, 1867-75
The Medical Monograph, January-December,

Partial files of

The Western Medical Journal (later the Kansas Medical Catalog) 1890-1903.

The Therapeutic Digest and Formulary, Kansas City, 1898

b. Notice of the Chartering of the college and appointment of faculty of the Kansas Medical College, clipped from the Kansas Daily Commonwealth, March 2, 1872.

c. Lists of courses offered by the Topeka School of Physical Education for Women and Children, Dr. Deborah K. Langshore, director, dated October 1,

1895.

d. Reference to an early Kansas doctor's duties, in C. C. Rister's "Southern Plainsman," University of Oklahoma Press, 1938, page 165.

e. J. W. McWharf's article on the early history of medicine, Volume 29, 1918, of Transactions of Kansas Academy of Science, Volume 29, 1918, Pages 46-49.

- f. An article, "Medical Progress as Shown in Treatment of Patients in Early Days Compared with Today," in the sixtieth anniversary special edition of the Great Bend Tribune, August 12, 1936.
- g. Material on the College of Physicians and Surgeons, organized in Kansas City, 1894; and the Kansas City Medical College, opened in 1897, both later absorbed by the Medical School of the University of Kansas.



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h. Numerous local society bulletins, such as those (recently) of the Sedgwick County Society.

i. Exhibit material such as:

Two cases of surgical instruments, one used by Dr. S. T. Marabie in the Confederate Army and after that in Silver Lake, Kansas; the other used by Dr. J. S. Redfield in the Civil War, 1861-65; thereafter in Ft. Scott, Kans.

Two pillrollers.

Two bleeding sets, with glass cups and lancets, in original cases; one lancet has "oblique blades . . . for a more copious flow of blood"; one belonging to the Dr. J. P. Koenitz collection, and the other donated from the equipment of John A. Reed's father, of Tecumseh.

The first x-ray picture taken in Kansas (1896). A hypodermic outfit for administering diphtheria antitoxin, used in 1902.

Several saddle bags used for medicine cases by early Kansas doctors, for example, those of Dr. Charles W. Hardy, who came to Waterville in 1886, used the bags until 1892, when he used his first horse and buggy.

A Columbus buggy used by Dr. McKnight of Hiawatha, 1901-12. Office furniture belonging to Dr. B. D. Eastman, of the State Hospital in Topeka.

9. The Kansas State Library, in the Capital, contains full data on legislation and considerable data on proposed legislation concerning medical matters.

V. Recommendations:

In the light of this preliminary investigation your

committee wishes to make the following recommendations:

1. That a semi-permanent committee be set up, with provisions for continuity, with the assignment of a definite budget allowance, and with instructions to proceed toward the collection, correlation, preservation, and recording of all available material and data pertinent to Kansas medical history.

2. That this committee consider the appointment of a paid secretary to insure the carrying through of the

details.

3. That this committee release to the editor of the Journal of the Kansas Medical Society appropriate material for brief sketches and historical articles each month.

4. That a definite relationship be established and fostered with the Kansas State Historical Society and its continued cooperation enlisted. This might lead, for example, to the establishment of a permanent medical museum.

5. That the data in the present report be put at the disposal of the new committee so that various suggestions herein made can be, if desired, followed up.

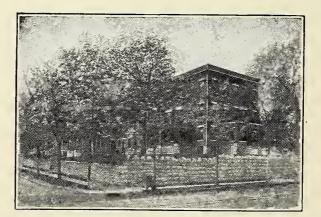
6. That for the new medical history committee the names of the following members should be carefully considered as likely to be of particular service on such a committee: Dr. C. H. Benage of Pittsburg; Dr. H. L. Chambers of Lawrence; Dr. M. J. Dunbar of Winfield; Dr. Frank Foncannon of Emporia; Dr. G. F. Gsell of Wichita; Dr. J. F. Hassig of Kansas City; Dr. C. F. Menninger of Topeka; Dr. L. S. Nelson of Salina; Dr. R. T. Nichols of Hiawatha; Dr. John Porter of Concordia; Dr. L. P. Ravenscroft of Winfield; Dr. O. D. Walker of Salina; Dr. W. L. Warriner of To-

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peka; Dr. O. B. Wyant of Winfield and Dr. Louis Zimmer of Lawrence.

Respectfully submitted,

Warren Morton, M.D.

Alfred O'Donnell, M.D.

Karl A. Menninger, M.D., Chairman

Committee on Medical History

The following is the report submitted by Paul E. Belknap, M.D., of Topeka, Chairman of the Committee on Child Welfare:

To: THE HOUSE OF DELEGATES:

There has been relatively little activity of this committee except in relation to the Emergency Maternal and Infant Care program.

During the year Congress liberalized the requirements of physicians participating in the program and the question arose whether it should be continued in the state. At a joint session held with the Maternal Welfare Committee it was recommended to the Council that it vote to continue with the same regulations which had been previously used.

Your chairman has been made a member of the Advisory Boad which controls the policies of administration and passes upon the merits of special cases.

One important change made during the year is the allowance made for immunization of the infant in the doctors office.

It is felt that the program, in spite of the obvious defects, is being administered in as fair a manner as is possible for the medical profession.

The following is the report submitted by E. M. Sutton, M.D., of Salina, Chairman of the Committee on Pharmacy:

TO: THE HOUSE OF DELEGATES:

The Committee on Pharmacy has remained inactive during the past year because, as chairman, I knew of no problem or business of sufficient urgency that would justify calling the busy, widely distributed members of our committee together for a meeting.

The following is the report submitted by Warren F. Bernstorf, M.D., of Winfield, Chairman of the Committee on Plasma:

To THE HOUSE OF DELEGATES:

Your committee has had considerable correspondence during the past year relative to the plasma situation in Kansas, as well as several discussions with individuals who should be most interested. The concensus of opinion is satisfactory as far as availability, distribution and general use are concerned.

Nothing has been done yet as regards the establishment of a central depot for collection and drying in Topeka, due to the fact that there seems to be no great demand for such a service.

The following is the report of the Committee on Post Graduate Study:

To: THE HOUSE OF DELEGATES:

The Post Graduate Committee carried on its program throughout the year, the first half of the year under the chairmanship of Dr. Philip Morgan, the

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APRIL, 1944

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Large numbers of physicians, educators and groups in the field of public health have expressed their appreciation for this work.

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second half under the chairmanship of Dr. Harold H. Jones. This change was made by the President because of the entrance into the armed forces of Dr. Morgan. Under a directive of the Council of the Kansas Medical Society the Post Graduate Committee met and made a survey of the post graduate field. First considered was post graduate medical education for members of this Society who are to return from service in the armed forces. A number of educational authorities were interviewed, a number of men from the armed forces and the endowment funds were also contacted. The consensus of opinion of your committee is that this project should be pushed forward, that it is the duty of every member of the Society to take part in the establishment of a fund for post graduate training as a gesture of homage and appreciation to those men who have gone into service. It is also the opinion of your committee that in conjunction with the Medical School of the University of Kansas and the Kansas State Board of Health, this fund can easily be raised and that it will be the beginning of a medical continuation center in the University of Kansas, open to all members of this Society. It further will improve the standard of education in this state by the establishment of a chair of preventative medicine, a chair of physical medicine and furtherance of the Department of Psychiatry. The members of the armed forces contacted have been very grateful for this gesture from the Society and hope that it can be carried to a final conclusion.

The Post Graduate Committee has carried on the regular post graduate clinics, the faculties have been strong and have been well received. It is the hope

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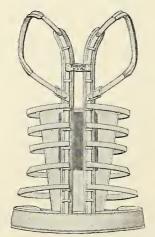
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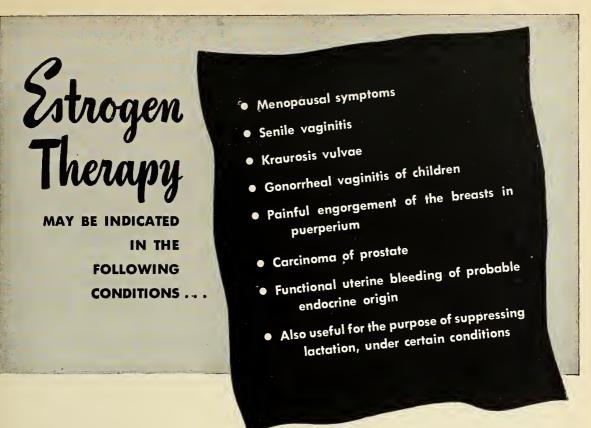


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of the committee that we can continue to offer to the Society facilities of equal caliber in the various fields of medicine not yet covered. The committee also considered the question of long-range post graduate study in the various centers throughout the state in conjunction with the Commonwealth Fund. This post graduate period contemplates twenty-four months' study at regular intervals. No further actions or recommendations have been taken on this phase of graduate education.

The committee wishes to take this opportunity to thank the members of the Council, to thank the members of the Kansas Medical Society for their excellent cooperation during this past year.

Respectfully submitted,

F. C. Beelman, M. D., Kansas State Board of Health Harold Inghan, Extension Division, University of Kansas Harold H. Jones, M.D., Chairman Committee on Post Graduate Study.

The following report is submitted by George I. Thacker, M.D., of Waterville, Chairman of the Committee on Public Health and Education:

To: THE HOUSE OF DELEGATES:

My connections with the State Board of Health has kept me in contact with the public health matters and there has been no apparent need to call the committee together, therefore, there is no report to offer.

The following is the report submitted by Edgar C. Duncan, M.D., of Fredonia, Chairman of the Committee on Public Policy:

To: THE HOUSE OF DELEGATES:

The Committee on Public Relations is attending items formerly looked after by the Committee on Public Policy. Our committee, therefore, has been inactive the past year.

No hits, no runs, no errors.

The following report was submitted by Ralph I. Canuteson, M.D., of Lawrence, Chairman of the Committee on Scientific Work:

To: THE HOUSE OF DELEGATES:

The Committee on Scientific Work held no regular meeting this year owing to the difficulty encountered in the members getting away from their practice at a suitable time and place.

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The competent work of the local committees on arrangements for annual meetings leaves little in that direction for the attention of this committee.

Pursuing our project of last year in the stimulation of interest in post praduate courses and in outlining an organization of the Kansas Medical Society, the State Board of Health, and the University of Kansas School of Medicine, the chairman of this committee met in Topeka with the representatives of the Post Graduate Course Committee, the Kansas Medical Society, the Medical School and the State Board of Health on December 12, 1943 for discussion of plans for post graduate courses for the immediate future and for the post-war period. A report on this meeting undoubtedly will appear from the Committee on Post Graduate Study.

The following is the report submitted by Robert P. Knight, M.D., Chairman of the Committee on Stormont Library:

To: THE HOUSE OF DELEGATES:

At the present time the Stormont Medical Library Fund yields about \$150 a year return on the \$5,000 principal invested and this income is about sufficient to pay for the journal subscriptions. Occasionally new books are bought by the State Library and placed in the Stormont Medical Library, and occasionally books are donated by Kansas doctors or by the Journal of the Kansas Medical Society which receives free books for review.

The library is used rather intensively by the medical officers of the Winter Hospital and of the Topeka Air Base and somewhat less intensively by Topeka and other Kansas doctors. The chief drawbacks are that the library is open only from 8:30 till 5 daily except Sunday, so that no access to it in the evening is possible. Also it is placed on the third tier of stacks on the third floor of the State House, necessitating the climbing of many steps to reach it.

The following recommendations are made:

1. That the Kansas Medical Society make plans leading to the formation of a medical library, using the Stormont Library as a nucleus, of the proportions and importance of the law library; that funds be sought from the legislature for this purpose; and that quarters be sought and provided perhaps in the projected new sections of the State House, to house the Medical



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Library in more accessible quarters. This should probably be a post-war ambition but will require planning beginning now.

- 2. That at the present time no changes be made in the policy of the library, which is operating well under the handicaps present, except that a number of the older and little used books be weeded out and stored to make room for current books and bound journals as they are acquired. The stacks are filled at present and many of the books are never used or called for.
- 3. That greater publicity be given to the advantages and uses of the Stormont Medical Library through the press of the Journal of the Kansas Medical Society and the Medical Bulletin of the Shawnee County Medical Society, pointing out the loan service available and the journals and new books received. A regular library column in the Journal might fill this need.

The following is the report submitted by G. M. Edmonds, M.D., of Horton, Chairman of the Committee on Study of Heart Disease:

TO: THE HOUSE OF DELEGATES:

Our chairman, Dr. Phillip W. Morgan of Emporia, has been called into the service, also a good many members of the Kansas Heart Society and it was decided to discontinue the post graduate course on heart disease which was held in Emporia each year until after the war. Dr. Samuel Levine of Boston has promised to come as soon as the war is over.

In the meantime Dr. H. H. Jones, a member of our committee, reports to me that he has arranged for a post graduate clinic on cardiac disorders. This program

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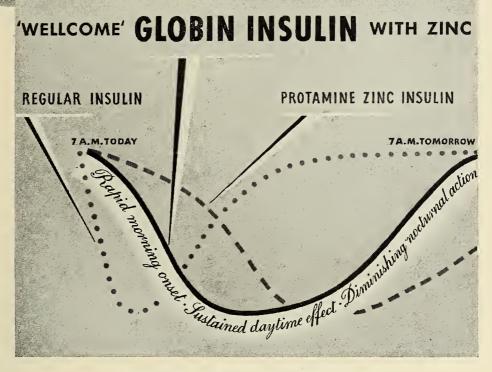
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is arranged by the Kansas Medical Society and will be held at several places over the state from April 15 to 23. Dr. Chauncey C. Maher, Associate Professor of Medicine of Northwestern University and George Walker, Assistant Professor of Pathology of the University of Kansas School of Medicine are to be the faculty for the clinic.

This program should be of interest to all physicians in the state of Kansas.

The following is the report submitted by Henry Haerle, M.D., of Marysville, Chairman of the Committee on Necrology:

TO: THE HOUSE OF DELEGATES:

I wish to inform the Society that the following of our members have died during the year on the dates given and from the causes described.

8				-
NAME	AGE	DATE	PLACE	CAUSE
Gates, Edward Davis Iliff, Winfred H. (Fred)	72	Jan. 23 March 2	Kansas Cit	У
			Baxter Springs	
Henderson, Archibald G		March 14	Leonard- ville	Coronary occlusion
Zerzan, George F.	64	March 22	Salina	Carcinoma of pancreas
Atkins, Herbert	62	April 10	Pratt	Acute coronary occlusion
Daniel, Herman P.	74	May 7	Wichita	Cerebral throm
				bosis & myo- cardial degen-
Dillingham, Wm. Roy	59	May 13	Wichita	eration Uremia &
Hill, Emma L.	84	May 15	Oswego	nephrosclerosis Auto accident
Tilden, Leslie Chapman		May 17	Oberlin	Carcinoma of
				liver, stomach & pancreas
Bishop, Walter D.	56	May 21	Kansas Cit	yCoronary thrombosis
Rea, Walton H.	65	May 26	Arkansas	Cerebral
Marshall, Albert Henry	67	June 7	City Topeka	hemorrhage Coronary
				thrombosis
Caswell, Charles E.	73	June 12	Wichita	Cerebral thrombosis
Nienstedt, Wm. F.	69	July 6	Hartford	Coronary
				thrombosis & sclerosis
Riley, Brett Redpath	72	July 16	Benedict	Coronary embolism
Ham, Wm. Emmett	85	July 31	Beattie	Chronic myo-
				carditis & apoplexy
Cox, Omar L.	76	Aug. 22	Iola	Carcinoma of colon
Fowler, Luther Wendell	67	Oct. 18	El Dorado	Carcioma of
				lung
Nelson, Charles R.	65	Oct. 18	Jamestown	Parkinson's disease
Berger, Alexander J.	59	Nov. 2	Parsons	Carcinoma
Ball, Orie Hugh	59	Nov. 2	Dennis	Generalized arteriosclerosis
Brown, Thomas Oscar	74	Nov. 12	Osage City	Adenocarcin- oma of prostate
Morton, Robert J.	85	Dec. 3	Clay Center	Bronchiopneu-
Dingess, Mathew Thompson	76	Jan. 8	Atchison	monia Pneumonia
Asher, Henry H.	33	Jan. 13	Manistigue,	Pneumonia 4
			Mich. (Formerly	y
Andorron Fred M	65	Ion 17	Topeka)	Cerebral
Anderson, Fred M.	6)	Jan. 17	Nickerson	hemorrhage
Cavanaugh, Frank A.	83	Jan. 18	South Haven	
Pinkston, James A.	82	Jan. 25	Indepen-	Diabetis
Horton, Joseph D.	77	Feb. 14	dence Plevna	mellitus Coronary
Jones, Frederick W.	72	Feb. 21	Girard	arteriosclerosis
Francisco, Clarence				
Benjamin	64	Feb. 23	Kansas City	Carcinoma of common bile
Scott, William J.	67	March 15	Baxter	duct
,			Springs	

The following is the report submitted by O. W. Davidson, M.D., of Kansas City, Chairman of the Committee on Venereal Disease:

To: THE HOUSE OF DELEGATES:

This committee made plans and established certain policies at the beginning of the year which were recommended to the State Board of Health. Considerable progress has been made in the matter handling the increase of problems that has come as a result of present war conditions. Post graduate clinics directed by the Extension Division of the University of Kansas under auspices of this committee were well attended and Drs. Pelouse of Philadelphia, Pennsylvania, and Berger of Wichita, Kansas, presented very worthwhile reviews on the subject of venereal disease.

URGES SHORT INTENSIVE COURSE IN PSYCHIATRY FOR ALL DOCTORS

Short intensive psychiatric training courses for physicians are very much in order, not only to meet the need of the armed forces for more psychiatrists but also for the tremendous postwar job in this field, Lieut. Col. William C. Menninger, Medical Corps, Army of the United States, Neuropsychiatric Consultant, Fourth Service Command, declares in The Journal of the American Medical Association for November 20.

"The second major concern confronting every physician both in and out of the Army," Colonel Menninger says, "is the number of psychiatric cases which the war experience has disclosed in our general population. The medical and social implications of this group are beyond our present ability to estimate.

"The third major problem confronting the Army psychiatrist is the rapid and most effective disposition of these maladjusted individuals in the Army. The first purpose of the Army is to win the war, and consequently these soldiers unfit for service must be given over to the care of civilian agencies and civilian physicians with the hope that they will accept the responsibility and provide treatment for these men in accordance with our most modern psychiatric concepts."

The psychiatric problems of the Army, Colonel Menninger explains, "should be of vital interest and concern to every citizen interested in the war effort and particularly to medical men. They should be of interest, first, because of the great number of men whose Army experience has brought to light their need for medical and particularly psychiatric help. This fact may be vividly portrayed by these figures: A average of eight to ten per cent of men examined for military service are rejected for psychiatric reasons, and nearly thirty per cent of the discharges from the Army are for psychiatric reasons. In contrast, only two per cent of the medical profession are psychiatrists. The social implication of these figures is enormous, but their importance to the medical profession is even greater.

"Every internist is aware of the fact that even in normal circumstances in our prewar practice between forty and sixty per cent of the patients seeking medical help present only functional disturbances. . . ."

The Colonel points out that, despite the lack of trained psychiatrists and the lack of facilities, the caliber of neuropsychiatry practiced in the Army is surprisingly good.

★ BUY AN EXTRA BOND

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STERNBERG AND THE FORT HARKER CHOLERA EPIDEMIC OF 1867

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Topeka, Kansas

General George Miller Sternberg may be justly considered one of the outstanding figures in American medicine, yet for reasons never clearly outlined he has not assumed the position he deserves in the writings of medical historians. This article consists of a biographical summary and commentary on Dr. Sternberg and the story of his connection with the epidemic of Asiatic cholera at Fort Harker, Kansas, in 1867.

BIOGRAPHICAL SUMMARY

Robert Koch once referred to Sternberg as the father of American bacteriology and Sternberg's Textbook of Bacteriology¹ is considered a milestone in its field. It was the first American textbook on this subject. The authoritative life of Sternberg has been presented in the biography written by his second wife². At intervals, few and far between, papers have been written about him, the last appreciation having been prepared recently³.

Sternberg was born on June 8, 1838, at Hartwick Seminary in New York. His father was a Lutheran Clergyman and educator. He spent his early years in the vicinity of his birthplace, attended school there and later taught school in that locality. While employed in this way, he studied anatomy and physiology under Dr. Horace Lathrop of Cooperstown, New York. After taking some preliminary medical courses in Buffalo he attended the College of Physicians and Surgeons in New York and received his medical degree in 1860.

Sternberg practised medicine in Elizabeth, New Jersey, for one year and then joined the Army as an assistant surgeon on May 28, 1861, at the age of twenty-three, for Civil War service. Within two months he was captured by Confederate forces at Bull Run but escaped and rejoined his own troops. He served with distinction throughout the war and re-

*The Menninger Clinic, Topeka, Kansas.

ceived the brevets of captain and major for faithful and meritorious service. Between 1865 and 1879 he served at various Army posts throughout the country and had much experience in Indian campaigns. He was rated as the Army's medical corps officer with the most combat experience of his time. During this period his experience with the Fort Harker epidemic of Asiatic cholera in 1867 enabled him to apply in later years the principles of sanitation which prevented the spread of the cholera epidemic of Hamburg to this country. Under adverse circumstances he pioneered in bacteriological research and created research facilities at his own expense. His fame gradually spread to the degree that he became world famous for his accomplishments. In 1881 he discovered the pneumococcus simultaneously with Pasteur but quite independently. Four years later he demonstrated for the first time in this country the plasmodium of malaria and soon afterwards the causative agent of typhoid fever. He was also the first in America to demonstrate the vibrio cholerae. He has been credited with being the first to demonstrate in America the tuberculosis bacillus but very recently there have been publications to refute this claim. There was much evidence attesting to his great conscientiousness and effort. He studied the problem of disinfection enthusiastically and wrote a famous paper which received the Lomb prize in 1886. It was translated into several foreign languages4. When working in Welch's laboratory at Johns Hopkins he supported Laveran's claims of the plasmodial etiology of malaria contrary to the beliefs of Osler and many other outstanding teachers.

Aside from his work on cholera, typhoid fever, and malaria, he made numerous studies of yellow fever and the publication of his first two articles on this subject, as a result of his previous experience, established him as an authority in this field. He had experienced many epidemics of this disease and his work virtually paved the way for the findings of the Yellow Fever Commission. In his textbook he mentioned the possibility that the etiological agent might not be a bacterial organism. The appointment of Walter Reed to head the yellow fever investigation was made by Sternberg after he had become Sur-

geon General of the Army wth the rank of brigadier general in 1893.

It is of interest to note that during Walter Reed's experience in the midwest he had occasion to discuss Asiatic cholera before a local county medical society, the interest arising because of the outbreak of Asiatic cholera in Europe. The cultures of the comma bacilli used in the demonstration were probably supplied to Reed by Sternberg and this took place in 1893 shortly before Sternberg's appointment to the surgeon-generalcy⁵.

During his term of office (1893-1902) Sternberg established the Army Medical School of which the fiftieth anniversary was recently celebrated. The Army Nurse Corps and Dental Corps, and the tuberculosis hospital at Fort Bayard came into existence at this time too.

Sternberg received many honors and his memberships in numerous societies are too lengthly to list here. Suffice it to say that two outstanding honors were his presidency of the American Medical Association and the American Public Health Association.

In 1902 Sternberg was retired from the Army but he maintained an active interest in public health and welfare until his death in 1915.

FORT HARKER

Fort Harker was established originally in August, 1864, as Fort Ellsworth and the site was the crossing of the old Santa Fe road⁶. The detachment of Iowa volunteers who were said to have erected and garrisoned the place were relieved in 1865 by part of the Thirteenth U. S. Infantry and in 1866 the name Fort Harker was first used. In January, 1867, a new site about a mile northeast of the old fort was selected. The cholera epidemic reached the fort in 1867. Five years later it was abandoned by the military and in 1880 the reservation was opened to settlement.

THE CHOLERA EPIDEMIC

Asiatic cholera had been existent in India for many years but in 1817 a great epidemic occurred and this spread to Europe. By 1832 the disease had come to the United States striking the northern coastal cities and traveling westward toward the Ohio River, eventually reaching New Orleans where as many as 500 deaths in one day were reported. The disease took its toll in St. Louis during 1849 and 1850. In 1855 it reached Kansas and affected the inhabitants of Fort Riley. Sternberg wrote in detail of the spread of cholera in his book about infection and immunity⁷.

In 1865 Sternberg was married and he went with his wife to Jefferson Barracks where they remained until 1866. His wife returned to her home and Sternberg proceeded to his new assignment at Fort Harker where he was joined by his wife in the spring of 1867. The epidemic of Asiatic cholera occurred during the summer of that year and Sternberg's report to the Surgeon General was brief and to the point⁸. It began with an account of the topography of the area, a statement concerning the water supply of the fort, and mention of the cases of diarrhea preceding the epidemic.

Company "E" of the 37th Infantry had arrived in October, 1866, from Little Rock, Arkansas, and diarrhea from intermittent fever was common. During the next five or six months nearly all cases of illness had improved. When the epidemic began, there were present a company of the 37th Infantry, three companies of the 38th United States Infantry (colored), a company of the 10th Cavalry (colored), and later on four companies of Kansas militia. In addition, there were five to eight hundred quartermaster's employees in and around the post during the epidemic.

Camp sanitation was not good at the onset of the epidemic. "Some of the company sinks were in wretched condition, and there were several offensive holes about the post where slops and garbage from the kitchen had been thrown." Sternberg wrote that remedial measures were taken immediately. The camps were moved to new grounds and disinfectants freely used. Hospital patients were treated in hospital tents pitched about fifty yards behind the post hospital. Convalescent and uncertain cases were kept apart from cholera patients and discharges from the patients were disinfected "as soon as passed."

The first case of cholera was a male civilian who was seen at 3 a.m. of June 28 in a state of collapse. He had "rice-water discharges from stomach and bowels, had been suffering from diarrhea for two days, but had not applied for treatment." He died at 3:30 p. m. of the same day. There were many cases diagnosed as choleric diarrhea which Sternberg decided later were mild cases of cholera and these were not included in his report. The record of cases in his report shows the date of onset as June 28 and the last day mentioned is August 1. There are listed a total of forty-seven cases with thrity-two deaths. These were cases only under his care. The records of Acting Assistant Surgeon Chase are mentioned and he reported seventy-nine cases with twenty-six deaths. Since several other physicians were present the total number of cases and deaths make quite a figure so that the epidemic has historical significance.

The report on treatment is as follows: "At first we tried the chloroform treatment, as recommended by Assistant Surgeon E. McClellan, in doses of from fifteen minims to one fluid drachm, repeated every half hour, or at larger intervals. The chloroform seemed to have a decided effect in controlling the diarrhea and vomiting, but I could not see that it had

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any effect in the way of producing reaction from a state of collapse. We afterwards adopted the calomel treatment, giving from ten to twenty grains every hour until three or four doses had been administered, and the results of this treatment were more satisfactory than of any others tried. A number of apparently hopeless cases rallied under this treatment, but were afterwards carried off by the consecutive fever. We used Squibb's mixture very extensively in the treatment of the prevailing diarrhea, and found it to answer admirably."

In his report, Sternberg mentioned atmospheric conditions at the time of the epidemic and indicated the prevalence of flies and mosquitoes. He mentioned the presence of "a large fly which differs from the common house fly." In addition, he stated that cases "could be traced to an attack of indigestion from the use of improper food, and others to the immoderate drinking of river water." The last sentence of the report reads: "One of the ladies of the garrison died of cholera on the 15th of July" and this refers to Sternberg's wife.

Although the time element was small, the clinical experience for Sternberg was invaluable. He had learned a great deal from his Kansas assignment as proven twenty-five years later when, as consultant at the quarantine station in New York and Director of the Hoagland Laboratory, he was called upon to prevent the spread of cholera to this country as a result of the great Hamburg epidemic of 1892. This disaster which took 8,600 lives and affected 17,000 persons was not repeated here and the honor goes to Sternberg for this "singular triumph of American preventive medicine."

SUMMARY

Some of the outstanding achievements of Sternberg have been mentioned briefly but no allusion has even been made to others. His early work on photomicrography was extremely important and his several inventions of household devices, such as a heat regulating mechanism, were extremely useful. The really important points to remember are that Sternberg was essentially the father of bacteriology in America, the author of the first American textbook of bacteriology, a leading Army Medical Corps officer who eventually became surgeon-general, and a stimulator of bacteriological and other scientific research among American men of medicine.

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POSSIBLE TRANSMISSION FACTORS IN POLIOMYELITIS*

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This study was undertaken to determine the incidence of certain epidemiologic factors among poliomyelitis patients, in the hope of throwing some light on the relative importance of each factor by ascertaining the frequency of its occurrence.

A uniform questionnaire was employed, and the information was obtained by personal interviews with the parents of poliomyelitis patients, or by direct questioning of patients old enough to furnish reliable information. The patients in the series were all given positive diagnosis for poliomyelitis on the basis of characteristic symptoms, together with pleocytosis of the spinal fluid or paralysis or both. The 100 cases used represent those which were available for interview following the beginning of the study and are otherwise unselected. With one exception, all cases included were admitted between July 1 and November 15, 1943, during which period poliomyelitis admissions totaled 125.

Most of the factors considered in the study have been the basis of previous investigations. Swimming in water contaminated by sewage has been cited^{1,2} as a possible means of spread. This apparently cannot be considered an important factor in the cases studied, only twelve patients having been swimming within three weeks of the onset of their illness.

The incidence of cases in which patients used water from shallow wells and had no other sanitary facilities than privies was surveyed because of suggestive findings reported by other investigators. In a rural outbreak studied by Langmuir³, several of the affected families used unprotected dug wells and unscreened privies. George and Ransom⁴ found that seventy per cent of all cases in the 1939 Des Moines epidemic occurred within two blocks of outside wells and toilets. Casey and Aymond⁵ report that the highest incidence of poliomyelitis in Louisiana over a ten-year period occurred in communities with water supply but without sewerage systems, rather than in frankly rural or larger urban areas.

Of the patients surveyed in the present study, thirty-six per cent were regular users of well water, eleven used cistern water and two had used spring

^{*}From the Departments of Orthopedics and Pediatrics, Wesley Hospital, Wichita, Kansas.

water. Fifty-four per cent lived within 100 yards of one or more outdoor toilets. Of the forty-five families who used outdoor toilets, ten had latrines of approved sanitary design.

The question of whether epidemics of poliomyelitis may be milk-borne is an old one⁶. Aycock⁷ concludes, "It seems probable that milk-borne epidemics of this disease are of the same order of frequency as epidemics of other infectious diseases which are occasionally transmitted through milk."

In the present survey, sixty-eight per cent of the patients studied had used raw milk for an indefinite period prior to their illness.

The proximity of poliomyelitis cases to livestock was also surveyed. Sabin and Ward⁸, after investigating the virus in insects, concluded, "We believe that the search for a reservoir of poliomyelitis virus among the lower animals is worth while and should continue. . . We are inclined to regard poliomyelitis as a disease which occurs the year round but has a greater incidence during the summer and autumn because greater dissemination of the virus may be made possible by a number of factors, including insects such as flies."

According to Toomey⁹, Flexner made efforts as early as 1910 to inoculate calves, goats, pigs, sheep, dogs, cats and the horse with poliomyelitis virus. His efforts with these animals were apparently unsuccessful. Toomey obtained suggestive results following the inoculation of a horse. Later he and his collaborators¹⁰ were unsuccessful in isolating the virus from dog stools.

In the present study, twelve per cent of patients were from families living within 100 yards of sheep or goats. Thirty-two per cent owned or lived within 100 yards of horses, thirty-eight per cent within the same distance of hogs and forty-eight per cent a similar distance from cows. Forty-eight per cent owned cats and fifty-nine per cent possessed dogs.

Domestic fowls may also constitute a reservoir of poliomyelitis virus. Flexner seems to have been unsuccessful in inoculating chickens with the virus9. Frauchiger and Bourgeouis¹¹ made histological studies of chickens suffering from paralysis, and concluded that paralytic disease of fowls and poliomyelitis are entirely different entities. The former, according to these authors, shows a spastic type of paralysis, sensory disturbances and no such predilection for the anterior horn cells as is characteristic of poliomyelitis. Toomey¹⁰, tested the spinal cords of chickens sick with paralytic disease by inoculating Eastern cotton rats. While the virus was not demonstrated, the cord suspension killed the rats and a lethal factor was transmitted for three doses. Chicken feces were apparently not tested for the virus.

Forty-six per cent of the patients in the present

study were from families owning their own chickens and an additional thirty-three per cent lived within 100 yards of chickens. Thus, eighty-nine per cent of the 100 patients surveyed had chickens on their own premises or within 100 yards of their homes.

A large number of species of domestic and wild fowl have been shown to be susceptible to infection with the virus of equine encephalitis. Hammon and his collaborators¹² found in one epidemic area positive neutralization tests in approximately one-half of 120 domestic or captive birds representing fifteen species and approximately one-fifth of 164 wild birds representing twenty-nine species. Infection rates were significantly higher in birds than in mammals. They conclude, "This definitely points to the rural barnyard and to the fowl-run of the semi-rural home as the chief sources of infection." Chickens have been found capable of carrying equine encephalitis virus without exhibiting clinical signs of the infection¹³. The similarity in geographic distribution of these two virus diseases, equine encephalitis and poliomyelitis, has been noted14. Moreover, observations in Kern County, California, have shown that human equine encephalitis may run a clinical course indistinguishable from poliomyelitis¹⁵.

The high incidence in proximity of chickens to poliomyelitis victims noted in the present study, the demonstrated ability of flies to carry poliomyelitis virus⁸, and the almost universal seasonal occurrence of flies in the vicinity of chickens, suggest a possible mechanism for the transmission of infantile paralysis.

All informants were questioned as to the occurrence of flies and mosquitoes about their homes. Eighty-three per cent acknowledged the presence of flies and sixty-two per cent, mosquitoes.

Six members of one family included in the study were severely bitten by mosquitoes while sleeping outdoors. All of those bitten were subsequently ill and three of the children developed paralysis. The mother and baby, who had slept indoors entirely, did not become ill. Members of the family attributed their illness to the mosquito bites.

Multiple cases of paralysis occurred in six of the ninety-five families represented in the survey, with two in each of five families and three in another. However, twenty-four additional families reported that one or more members manifested symptoms suggesting the abortive type of poliomyelitis at or near the time of the onset in the proved cases.

Thirty-five of the patients came from farms, forty were from Wichita, and the remaining came from towns of various size in Kansas.

Nine cases were from isolated rural areas twentyfive miles or more from any other known case. Four of these were reported as the only known cases of

(Continued on Page 171)

President's Page

To the Members of the Kansas Medical Society:

We have just completed one of the best annual meetings of the Kansas Medical Society that we have had for years. The doctors seemed to be hungry for a meeting of this kind after being on a two year fast and enjoyed the meeting like a hungry man enjoys a good meal.

The past year under Doctor Lattimore has been a very successful one and the coming year depends upon every member of the Society doing his part and not on the officers alone. We hope that every member, committeeman and officer realizes this and will do all or more than his share to make the coming year a success.

Sincerely,

M. Truche

President, the Kansas Medical Society

EDITORIAL

ANNUAL MEETING A SUCCESS

If you did not attend the 85th annual meeting of the Kansas Medical Society in Topeka, May 10 and 11, you missed one of the best meetings in many years. Perhaps the cancellation of last years scientific session had much to do with the total registration of more than 600, which included the physician membership of approximately 400, who eagerly attended every scientific and business meeting scheduled. Wednesday morning the halls of the Topeka Municipal Auditorium were crowded with officers, councilors, and county society representatives to the House of Delegates meeting intent upon the important Society work at hand. All business meetings had been scheduled to avoid conflict with the scientific session and as a result were well attended.

The most pertinent medical, surgical, war medical, rehabilitation, eye-ear-nose and throat, and public health subjects were condensed by the speakers to give "information hungry" doctors of medicine in Kansas the latest knowledge in these fields. Due to the serious illness of Dr. John S. Coulter of Chicao, one of the guest speakers, the program committee was able to fill his place on the program through the kindness of Lt. Col. Herbert C. Merillat of the Topeka Army Air Base with two officers from that hospital. Major Harold E. Simon talked on "Muscle Hernia" and Capt. Joseph W. Coock gave a case report and review of the literature on "Polycythemia vera." Both speakers were especially thanked and their subjects were received with much enthusiasm.

Those in charge of the House of Delegate and Council meetings had instigated an accelerated program and a tremendous amount of Society business was transacted in record time. The Kansas Physicians' Service Plan was passed by unanimous vote, and an expanded post graduate program for returning veterans and members was approved. Other details of the business meeting will be found in another part of the Journal.

It was announced to the membership and the press that Mr. Oliver Ebell of Wichita, the executive secretary of the Sedgwick County Medical Society, had been secured as the new Society executive secretary and would assume his duties on July 1, 1944.

As at all state meetings a few unpredictable difficulties arose and one of these was the failure of more than one technical exhibitor's equipment to arrive in time for the meeting. The equipment had been delayed or lost in transit, from one meeting to

another, and therefore more than one booth was sans equipment for display but the products and the companies were so well known that the men in attendance at these booths visited with the doctors in a highly satisfactory manner, we were told.

A great deal of favorable comment was heard on the 1944 meeting in general, on arrangements, choice of speakers, topics, reduction in time and in the capable way in which the session had been planned. A Past President was heard to remark: "It was a great meeting. The first in years that they didn't give me a lot of work to do and I had a fine time just attending all of the meetings and seeing and visiting with the men again."

NEW OFFICERS

The Kansas Medical Society membership has made a wise selection of its new officers for the year 1944-1945 who will direct and inspire the Society action in its continuation of war activities, expansion of post graduate education and its institution of the newly approved Kansas Physicians' Service plan for the state. W. P. Callahan, M.D., of Wichita is the new President-Elect; W. M. Mills, M.D., of Topeka the new First Vice-President; L. S. Nelson, M.D., of Salina the new Second Vice-President; and J. L. Lattimore, M.D., of Topeka the new Treasurer. F. R. Croson, M.D., of Clay Center was re-elected as the Society Secretary.

The sincere interest of each one of these men has already been demonstrated in service on various committees and committee chairmanships and in addition to this Dr. Callahan has served as Councilor from the Sixth District; Dr. Mills has served as Editor and Chairman of the Editorial Board of the Journal of the Kansas Medical Society since 1934; Dr. Nelson has served as Councilor of the Eighth District and is now the Chairman of the Defense Board; Dr. Croson has served as Councilor from the Seventh District and Dr. Lattimore your retiring President has served as Councilor from the Fourth District. Dr. Lattimore was elected to succeed Dr. Geo. M. Gray of Kansas City who had served as the Society's Treasurer for the past twenty-four years. It was at Dr. Gray's instigation a Topeka man was selected to facilitate the business of the Society and to be more accessible to the central office.

The following four Councilors were re-elected: Frank Fonconnon, M.D., of Emporia for the Fourth District; John L. Grove, M.D., of Newton for the Fifth District; J. H. A. Peck, M.D., of St. Francis for the Ninth District; and John R. Campbell, M.D., for the Eleventh District.

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VARIOUS FREEDOMS

The enunciation of the Four Freedoms established a goal to thrill the hearts of free men and bring hope to the subject masses of less fortunate countries than our own. The thought of freedom has always been an inspiration to mankind—a torch that has lighted the steps of many millions of feet, regardless of where their path ended. Sought after by the majority of all world's inhabitants, freedom remains an elusive abstraction,—a will-o'-the-wisp,—the concept of which may assume as many forms as there are minds to entertain it.

It was a canny idea to enumerate certain freedoms in the plural number for there is not and cannot be such a thing as pure, unmodified freedom; personal freedom must always be qualified by the right to freedom of others and must always be restricted by the natural boundaries that are set to our thoughts and to our enterprises. It is a bold stroke to promise even certain freedoms to others. It is something else to guarantee the survival of these freedoms, or even their temporary enjoyment.

In those shadowed sections of the globe where freedom has been totally eclipsed, any kind of an emancipation is going to seem, at first, a sufficient goal. Later on, when the eye has become accutomed to the initial light, the qualifications and restrictions will be seen, and it will be noted that liberty can appear in various shades and colors.

The people of the United States, having set out to assure at least four freedoms (including the freedom from fear, from which no one is free) to the stricken people of the world, might do well, without pausing in this task, to see how freedom is working out in our own country. It becomes increasingly apparent that we must learn, if we wish to consider ourselves as the exponents of democracy before the world, that true democracy can exist only where its benefits are considered as a sacred trust and are spread equally over all the people without regard to race, creed or color. In this we have failed in that we have allowed ourselves to develop and nourish feelings of class hatred, of race and color discrimination and of religious prejudice. Democracy, tough as it may be when faced with dangers from without, is highly susceptible to dangers from within, and we can flourish only when its freedoms are uniformly distributed.

It will require a consistent, conscious effort of all thoughtful people to overcome the prejudices on which they have been raised, and to measure each man by his own worth rather than by the color of his skin, the cast of his countenance, or the building in which he worships, but it is the task to which we must set ourselves, and it must be reciprocal. These

problems that we have allowed to develop will continue to rise and accuse us, and we are going to have our hands full with them.

Bureaucracy will try to keep its hand on the helm and increase its powers, as it has always done, and, since bureaucracy is essentially sadistic, it will constitute an ever-present threat to democracy and those freedoms that are still left after the fight for freedom is finished. Here, too, lies our own greatest danger, in the federalization of medicine practice. If this comes in, individual enterprise goes out, and another freedom with it.—New England Journal of Medicine.

MEDICAL SCHOOL

THE PATHOLOGIC PHYSIOL-OGY OF HYPERTENSION

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Hypertension is now recognized as probably the chief cause of death in this country¹, approximately 350,000 persons² each year die as a direct or indirect result of high blood pressure. Such a large number of deaths is ample justification for the extensive investigation of the causes and effects of hypertension which has been in progress for the past fifteen years. It is a curious fact that in spite of the world wide interest in this problem, there is as yet no universally accepted standard or level of blood pressure than can be considered normal³. The question, what is normal blood pressure, is decidedly pertinent to any discussion of hypertension, but unfortunately it cannot be answered in unequivocal terms; there is variation in the normal individual under a wide variety of conditions, such as age, exercise, diet, emotional states, fatigue, etc. For this and other reasons no patient should be considered to have abnormal blood pressure until after many determinations have been made under various conditions. It is the long time trend that is a true indication of the situation in cases of incipient hypertension. In those patients whose pressure persistently remains above 150 systolic and ninety diastolic, there is little doubt but that a disturbance of the blood pressure controlling mechanisms exists.

There are many factors that can, theoretically, play a part in the determination of blood pressure. Thus it is obvious that total blood volume, blood viscosity, cardiac output, and peripheral resistance may play a part in determining the level of pressure within blood vessels. There are cases in which one or more of these factors is abnormal, low blood volume from hemorrhage results in a fall of blood pressure, in shock a disparsity between blood volume and the volume capacity of the blood vessels results in low pressure. Conversely an increase of peripheral resistance, viscosity, blood volume or cardiac output can result in elevation of blood pressure unless compensatory mechanisms operate to prevent it.

In clinical hypertension there is an increase in blood viscosity and cardiac output, but the chief factor responsible for elevation of pressure is an increase in peripheral resistance. The problem of hypertension is therefore the problem of what may cause an increase in peripheral resistance.

There are many known factors that may produce a transient rise in blood pressure, such as asphyxia, emotional states, various intoxications, lead poisoning, any severe pain, increased intracranial pressure, etc. Such transient factors rarely jeopardize life, their presence is usually not difficult to detect, and the treatment is clearly indicated, at least in principle. It is the causes of chronic hypertension that are of greatest importance and most difficult to elucidate.

Sachs² gives the following classification of the causes of chronic hypertension:

- I Neurogenic
 - 1. Psychogenic
 - Midbrain and brain stem lesions
 - 3. Increased intracranial pressure

II Endrocine

- 1. Adrenal tumors
- 2. Pituitary tumors
- 3. Ovarian tumors
- 4. Menopause
- 5. Hyperthyroidism

III Renal

- 1. Acute and chronic glomerular nephritis
- 2. Chronic pyelonephritis
- 3. Polycystic disease
- 4. Renal tumors
- 5. Amyloidosis
- 6. Infarcts
- 7. Toxemias of pregnancy
- Disease and malformations of the renal arteries
- Coarctation of the aorta
- 10. Nephroptosis and nephrolithiasis
- 11. Obstruction to the urinary passages
- 12. Hydronephrosis
- 13. Postoperative renal lesions
- 14. Perinephritis

IV Unknown

- 1. Essential hypertension
- 2. Malignant hypertension.

One cannot safely say that all patients with chronic hypertension are victims of the same kind of disturbance of the vasopressor mechanism, there probably is not any single fundamental cause for all hypertensions, there are many causes. Thus in Group I psychogenic disturbances, emotional states, worry, mental disease, and other disturbances of cerebration may be associated with such a flood of nerve impulses radiating into the vasopressor center that a state of hypertonus of the sympathetic system is maintained for long periods of time; one manifestation of this can be increased peripheral resistance and hypertension. Brain stem lesions such as tumor or hemorrhage can cause swelling or pressure on the vasomotor center leading to anoxia and resultant increase of vasomotor tonus. In Group II the immediate mechanism is dependent upon increased production of vasopressor substances in the case of adrenal tumors and pituitary tumors. Ovarian tumors may contain cells like those of the adrenal cortex but many do not, the relation of hypertension is not clear. The menopause probably represents a severe endrocine upset with associated disturbances in the vasopressor mechanism, again not clearly understood. Hyperthyroidism may act by general increase of metabolic activity, increased cardiac output or vasopressor hyperactivity.

Group III includes all of the renal lesions that are known to be sometimes associated with hypertension. More than one hundred years ago Richard Bright (1789-1858) realized that there was some relationship between chronic disease of the kidneys and hypertension. He had no means of knowing what the exact renal lesions were, microscopic examination was then impossible and did not develop until shortly before Bright's death in 1858, but his clinical acumen was great and his name has since come to be associated with kidney disease in general. The term "Bright's disease" does not signify any particular type of renal lesion, the patients he described probably had chronic or acute glomerular nephritis in most instances.

After Bright had pointed out the clinical relationship between kidney disease and hypertension many efforts were made to learn what changes in the kidney might be responsible. Tigerstedt and Bergmann⁴ in 1898 prepared by extraction methods applied to the normal kidney a pressor substance which they called rennin. They postulated that a defective excretion of this material in kidney disease and its resultant accumulation in the circulation was responsible for generalized vasoconstriction. This conclusion came, as will be seen, remarkably close to the modern conception of the production of hypertension in renal disease.

Another view developed at about the same time

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was that renal disease resulted in narrowing of the arteries within the kidneys and that the resultant resistance to the flow of blood through the kidneys was the cause of hypertension. There is no valid evidence that such a localized increase in resistance can be responsible, on the contrary, removal of the kidneys from most animals, the rat excepted, will not lead to an increase in blood pressure.

In all the kidney lesions listed under Group III there are factors operating to reduce the flow of blood through the kidneys, this suggests that renal ischemia is in some way responsible for hypertension. That this is true now has been established beyond all question. There are, however, many hiatuses in our knowledge of just what occurs, and why,

Many investigators have shown that compression of the renal artery will cause a rise in blood pressure. Goldblatt⁶ and his associates were the first to show that this procedure causes consistently a marked and permanent hypertension. Constriction is affected by a specially devised adjustable silver clamp. Ischemia of one kidney produced in this way, the other kidney remaining intact, will cause a moderate elevation of blood pressure beginning in about three or four days but returning to normal in about one month. If, however, one renal artery is constricted and the other kidney removed, or both renal arteries constricted, the result is pronounced hypertension which persists apparently indefinitely. Some of Goldblatt's dogs are now living nearly ten years after such constriction, and still show high blood pressure. The severity of hypertension depends upon the degree of curtailment of blood flow and unless the constriction is extreme the elevation of pressure is not accompanied by any evidence of impaired renal function and the kidneys show little histological change. With severe constriction renal insufficiency develops and the animals die in uremia. The hypertension and uremia are accompanied by widespread degenerative changes in the systemic arterioles. Such changes are closely analagous to the picture of malignant hypertension as seen clinically. Goldblatt was unable to produce the changes found in the arteries of the human kidney for two reasons, a severe degree of hypertension could not be produced as long as one non-ischemic kidney remained in place and the ischemic kidney was necessarily excluded from the effects of high pressure since it lay in a region of low pressure. It is, therefore, clear that experimental renal ischemia will produce, depending upon its severity, a picture that is in all essential respects identical with that of benign or malignant hypertension in the human

The problem which this experimental work suggested, namely what is the mechanism of hypertension as a result of renal ischemia, has been partly,

but only partly solved. It was clear that the interferance with normal flow of blood was in some way related to the elevation of pressure. Several possibilities at once came under consideration.

- As Tigerstedt had suggested, it might be that kidney damage interfered with the normal rate of excretion of rennin.
- 2. Lack of oxygen might be responsible for the appearance of a pressor substance.
- 3. Reduction of pulse pressure might be the cause of abnormal accumulation of a pressor substance.
- Hypertension might be the result of reflex nervous mechanisms arising in the damaged kidney.
- Anoxia might stimulate the secretory activity
 of some hitherto unknown endrocine tissue in
 the kidney.

Two of the above possibilities (numbers one and four) can be definitely ruled out. There is evidence tending to support each of the remaining possibilities.

It is now definitely established that renal hypertension is due to reduction in blood flow through the kidney and that such reduction leads to the production of a pressor substance. It has not been easy to demonstrate that there is in the blood of a hypertensive animal any substance of the sort indicated. The blood pressure of a normal dog is not elevated by transfusing it with blood from a hypertensive dog, extracts of ischemic kidneys have yielded conflicting results, as have crossed circulation experiments. On the other hand there is convincing evidence that such a substance exists. Thus the plasma of a hypertensive animal is vasoconstrictive when perfused through the blood vessels of a toad, transplantation of an ischemic kidney into the neck of a nephrectomized animal will cause elevation of blood pressure, extracts of an ischemic kidney contain a vasopressor substance which has been called rennin because it probably is the same substance that Tigerstedt found in extracts from normal kidneys.

Rennin has now been secured in more or less pure form and is under investigation as to its chemical structure. The purified substance is not a pressor principle⁶, it only becomes such when it combines with the alpha globulin fraction of the blood proteins, the reaction leads to the formation of a substance which Page⁶ has called angiotonin. Angiotonin is heat stable and ultrafilterable but it is destroyed by the addition of more rennin according to Page (the possibility that rennin and angiotonin are not mutually destructive but rather that a molecular rearrangement occurs resulting in the formation of a substance which is not vasopressor has not so far been explored).

Continued injections of rennin become less and less effective in producing hypertension, this phenomenon has been called tachyphylaxis by Page⁶, who attributes it to exhaustion of rennin activator and consequent failure of angiotonin to be formed. Tachyphylaxis may, however, be due to compensatory increase of anti-rennin, a substance apparently produced by the normal kidney. (The normal kidney yields by extraction methods a substance which inhibits the action of rennin.)⁷ Anti-rennin is now being investigated as to its chemical structure and is being tested clinically with somewhat encouraging results.

The manner in which rennin is produced remains a mystery, anti-rennin is equally obscure as to its method of production.

It is a curious fact that histologists and pathologists have been, until recently, almost oblivious of the fact that there are in the kidney groups of cells that may readily have an endocrine function. These were first described by Zimmerman⁸ in 1933. I have yet to find in any text book of pathology or histology any accurate figure depicting these cells, or an adequate discussion of their histology. It is well known that the renal functional unit or nephron consists of a glomerulus with its afferent arterioles, a proximal and distal convoluted tubule and the loop of Henle, connecting into a short collecting duct which leads more or less directly to the renal pelvis. It is not so well known and it is little appreciated that at the point where the distal convoluted tubule lies in close contact with the afferent arteriole just before that vessel enters the glomerulus, there is a change in the structure of the wall of the tubule and the wall of the arteriole9 8. The blood vessel loses its elastic membrane, the endothelium becomes discontinuous, and the muscle fibers are overlaid and in part replaced by a cushion of myo-epithelioid cells (polkissen zellen-Zimmerman⁸); the wall of the distal convoluted tubule at the same point is lined with tall columnar cells whose nuclei are closely packed together and their cytoplasm often shows vacuoles and eosinophilic granules (Kaufmann⁹) strongly suggestive of a secretory function. This area of modified epithelial cells was called the macula densa by Zimmerman⁸. Together with the part of the arteriole nearby it constitutes the juxta glomerular apparatus of Goormatigh¹⁰, who was the first to suggest that the structure might be an endrocine organ.

That the juxtaglomerular apparatus of Goormatigh may be the site of formation of rennin is an hypothesis that has only recently come under investigation. In September, 1942 Kaufmann⁹ reported the results of a study of four hundred kidneys removed at operation or autopsy, concluding that the apparatus is well developed and constantly present in the human

kidney and that the histological characteristics of the structure are consistent with the possibility of an endrocine function. Goormatigh reported¹⁰ hypertrophy and hyperplasia of the cells in this apparatus in experimental and essential hypertension. On the other hand, since this discussion was presented at Wichita in December, 1943, Oberling¹¹ reported that a study of this apparatus in "hundreds" of cases has failed to prove that there is any consistent relation between hypertension in the human being and the degree of hypertrophy of the juxta glomerular apparatus.

Whatever may prove to be the site of rennin formation, it is clear that those forms of nephritis listed in Group III as being sometimes associated with hypertension are disease processes in which there is some cause for renal ischemia, which leads to the production of abnormal amounts of rennin which then combines with the alpha globulin fraction of the blood proteins to form angiotonin, this pressor material then causes elevation of blood pressure.

The great majority of hypertensive patients do not have manifest kidney disease, these constitute the group designated as "essential hypertension," or in the rapidly progressive form "malignant hypertension," who may eventually develop clinical evidence of nephritis but not for some years after the onset of hypertension. What is the mechanism in these patients? The answer to this question has been difficult to find. Extensive studies of renal function under normal conditions by a variety of methods have revealed much information and have led to the development of methods which permit accurate determination of renal blood flow, glomerular filtration rate, tubular excretory mass, etc. We are particularly indebted to H. W. Smith¹² for the development of the diodrast and inulin clearance methods which reveal how much blood flows through the kidney per unit time. Application of these methods to the study of human kidney function has shown that there is a significant decrease in blood flow through the kidneys in patients with "essential hypertension," in spite of which there is no evident renal insufficiency so far as excretion is concerned. Essential hypertension is therefor believed to be renal in origin, if true this fact removes the two groups of patients from the idiopathic or unknown group, and places them in Group III, the term "essential" should no longer be used. No widely accepted term to substitute for "essential" has made its appearance, such terms as "renal ischemic hypertension or "nephropathic hypertension" have been suggested. The question as to what causes the renal ischemia in the first place remains unanswered except in a general and statistical way. It seems clear that there is an hereditary factor involved, constitutional characterMAY, 1944

istics also play a part. Perhaps the "nervous" high strung individual with a poor hereditary background who has an unstable nervous system is more susceptible to the irritations of modern life and suffers in consequence a chronic hypertonicity of the sympathetic nervous system, one result of which may be renal ischemia of sufficient degree to cause excessive production of rennin; once this has begun the rennin tends to maintain the vascular constriction and hence to perpetuate the hypertension, a vicious cycle is then established and the individual becomes one of that large group of "essential hypertensives," without manifest evidence of renal functional disturbance for, in some instances, many years. If the severity of constriction is great the picture of "malignant hypertension" develops, the progress is quite rapid and various complications supervene to terminate the picture in a relatively short time.

It seems logical to suppose that a rational attack on the clinical problem presented by these patients should include the use of all known methods having the effect of dilating arterioles. Unfortunately there is at present no reliable method of bringing about this dilation for more than a relatively short time. It is to be hoped that the future may reveal some way of breaking up the vicious cycle.

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I have three personal ideals. One, to do the day's work well and not to bother about tomorrow. The second ideal has been to act the Golden Rule, as far as in me lay, toward my professional brethren and toward the patients committed to my care. And the third has been to cultivate such a measure of equanimity as would enable me to bear success with humility, the affection of my friends without pride, and to be ready when the day of sorrow and grief came to meet it with the courage befitting a man.-Sir William Osler.

POSSIBLE TRANSMISSION FACTORS IN POLIOMYELITIS

(Continued from Page 163)

poliomyelitis in their respective counties. One victim had been a surgical patient continuously for seven weeks in a hospital until the onset of poliomyelitis.

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AUTHOR'S NOTE—Thanks are due to Dr. A. E. Bence, Head of the Department of Orthopedics and Dr. F. L. Menehan, Head of the Department of Pediatrics of Wesley Hospital, for permission to study the poliomyelitis cases on these services, and to Dr. Thor Jager for reading the manuscript.

TUBERCULOSIS CONTROL

INTRAPLEURAL **PNEUMONOLYSIS**

It seems generally agreed that at least half the cases of pulmonary tuberculosis require some form of collapse treatment, either reversible or irreversible. Thoracoplasty is the best surgical example of the latter, while the oldest technique devised—pneumothorax—is a good representative of temporary, reversible collapse of the lung.

The chest specialist is the one to select either method after he has evaluated the patient's condition and the stage of his tuberculosis. The mistaken belief that "time heals everything" must give way to acknowledgement that this disease demands immediate consideration invariably and active methods of treatment whenever indicated. In this race against time, presence of a cavity calls

for measures to obliterate it before delay invites a hemorrhage or spread results in a hopeless condition.

Pneumothorax remains the first choice, but is successful in only about half the cases in which it is initially tried. Lack of success may be attributed to adherence of the two pleural surfaces so that collapse of the cavity is impossible or incomplete. Delay in the institution of pneumothorax may allow the parenchymal inflammation to progress and involve the pleurae until adhesions form and so defeat later attempts at what should have been a simple collapse procedure.

Formerly, a risky method attempted to stretch or break such adhesions by forcing air into the pleural cavity under positive pressures. Serious complications developed if the adhesion, breaking off near the lung, tore the latter so that a tuberculous or mixed infection empyema resulted. Serious hemorrhage might follow rupture of a sizeable vessel incorporated in the adhesion. Precious time was often wasted while the hoped-for stretching of the adhesion was awaited. Meanwhile the still unaffected cavity might supply bacilli to cause other cavities elsewhere.

Intrapleural pneumonolysis was designed to transform, where feasible, a poor pneumothorax result into a satisfactory collapse. Under local procaine infiltration anesthesia, a special cannula is introduced between the ribs into the pleural space, transmitting a visual instrument not unlike a cystoscope. Through this the operator views the interior and by means of a cautery inserted through a second cannula in another interspace severs the adhesions under direct vision.

Adhesions vary in size and shape and may be multiple. They range from "fiddle string" to short, thick and cylindrical, or may resemble accordian pleated sheets that radiate in all directions and run all the way from paper-thinness up to bands one or several centimeters in diameter. In using the cautery it is necessary to remember that thicker adhesions may contain lung tissue or large blood vessels and that they may be attached firmly to the aorta, subclavian artery or vital mediastinal structures. Great skill is required to avoid disasters similar to those already listed above as chargeable to stretching and rupture of adhesions.

A skilled operator will sever an adhesion as near its parietal extremity as possible, thus protecting the lung while exercising due caution as regards the intercostal structures as well, especially if actual dissection in the latter area proves necessary. In competent hands, backed by adequate experience and judgment when and when not to cut, the operation is a minimal one as regards the patient's discomfort. In less experienced hands, however, it can present dangers exceeding those of almost any other major intrathoracic surgical procedure.

When a pneumothorax is started and adhesions can be seen to interfere with collapse, provided the space is large enough for the surgeon to manipulate his instruments, there is no reason for delay. Besides the well-known hazards of an open cavity, the longer one waits the thicker grows the pleura covering the bands and the greater the difficulty of cutting them.

Very large adhesions may have to be severed partially at one sitting and finished in stages after waiting periods of three or four weeks have intervened. Adhesions too widespread to submit to this method call for abandonment of the unsuccessful pneumothorax and the selection at once of a collapse procedure other than pneumonolysis.

SUMMARY

- 1. Remember the time factor and begin active pneumothorax treatment immediately upon an individual who has a cavity. Don't wait to see what happens to the case with prolonged bed rest. Too often the realization will be accompanied by disappointment and chagrin.
- 2. In about half the cases a pneumothorax will be complicated by adhesions.
- 3. Don't attempt to stretch adhesions by means of a positive pressure pneumothorax.
- 4. Make an attempt to sever them by intrapleural pneumonolysis—again remembering the importance of time—as soon as possible.
- 5. In the hands of an expert, the unfavorable consequences of the operation are insignificant and the complications rare, but when performed by one with little experience, the dangers are very real.
- 6. If it is impossible to improve the collapse by pneumololysis, abandon the pneumothorax and perform a thoracoplasty.—Intrapleural Pneumonolysis, Lt. Comdr. James E. Dailey, M. C., U. S. N. R., Diseases of the Chest, Nov.-Dec., 1943. (Reviewed and passed by The Bureau of Medicine and Surgery, U. S. Navy.)

Improved health conditions are in evidence on a broad front Yet on all sides we encounter much disability and many deaths due to diseases for which we have adequate means of prevention and control.

Tuberculosis stands out prominently as one of the chief offenders in this group. Sixty thousand annual deaths represent but a small part of the penalty paid by the America people for failure to eradicate this disease. It is estimated that half a million persons in the United States have tuberculosis...yet the vast majority of this group will not be given the advantages of early diagnosis and early treatment. This presents a public health problem of major significance.—H. D. Lees, M.D., Social and Economic Aspects of Tuberculosis.

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MEN IN SERVICE

Dr. R. R. Melton of Marion was kind enough to send us the following information for this column:

Capt. L. W. Hatton formerly of Salina is stationed at Sheppard Field, Texas.

Capt. G. G. Robinson, formerly of Tate, Georgia, and Humansville, Missouri, and a graduate of the University of Kansas School of Medicine in 1933 is stationed at the Army Air Field, Pierre, South Dakota.

Capt. Norman (Slick) Siebert formerly of Marion has recently returned from two and a half years in the Aleutians and has transferred to the paratroops and is stationed at Camp McCall, North Carolina.

Retiring President Dr. John L. Lattimore has received many letters from our doctors over seas and has recently saved a few from which the next bits are abstracted. Thanks, Dr. Lattimore and to Mae too who sees to it that they get to the Journal office.

Capt. Frederick L. Ford of Topeka writes: "We are now living as guests of the good people of the British Isles. We like everything about them except that they cannot breathe in temperatures above 50 degrees and my exhaled breath as I write is plainly visible. May I receive future copies of your valuable sheet. I shall try to provide you with news of this theater when censorship restrictions are ameliorated. My love to one and all. Light the fire under Dr. M. L. Bishop: I have written often—he never."

From Lt. Col. W. C. Menninger in the Surgeon General's office of the War Department with offices in Washington, Dr. Lattimore received the following: "I always enjoy reading your notes. I join you one hundred per cent in decrying the tight wads who won't buy Government bonds. You'd think everyone thought he was giving his money to the Government instead of actually lending it at the highest rate of interest he could possibly get anywhere. My life keeps going on a terrific tempo with at least a seventy-five hour week."

Capt. F. C. Taggert of Topeka writes: "Dear Doctor John (Lattimore): For some time I have intended writing to thank you for the good newsy letter and also to change my address. I enjoy your communiques so much I don't want to miss any. As you can see I am in the "spam hels" but very well situated in a beautiful part of the U. K. and in a well built British constructed hospital. We are gradually learning to use some of the equipment which is good but different. I am still in the work I wanted to do and imagine that before long will have plenty.

Have been able to travel a lot and have seen some of the nearby cities. They have an air of quaintness and antiquity that you don't find in our oldest cities. The people live much more frugally than our people and I think take the war in a good spirit considering they have been at it four years. They aren't much for comforts as we know them—can stand 50 degree bathrooms and no central heating with spartan courage. It is a splendid education to be here but I shall be happy to go back home and stay for the rest of my span.

Have seen none of the other Topekans as yet. I called

Charles Joss' camp but found him gone for a few days. I still expect to run into some of them. Give my best to all the gang and drop me a note if you can find a minute."

A v-mail letter to Dr. F. R. Croson, the Secretary, from Major James R. Nevitt of Moran is as follows: "Thanks for my 1944 membership card in the Society which I recently received. Request that the Society do everything within its power to oppose the socialized medical acts that we hear are being promoted back in the states, until such time as we in the armed forces may be there to protect our rights. Every member of the medical profession I have talked to about this matter opposes it and fear it will be put over while we are gone. Aren't we sacrificing enough as it is? Let alone to come back and be regimented further."

Lt. Comdr. B. I. Krehbiel of Topeka and Lt. Comdr. John Porter of Concordia were in Topeka we were told although we didn't see them in the central office. Dr. Porter is now on the west coast and Dr. Krehbiel is stationed at the Great Lakes, both recently returned from the Southwest Pacific.

Major H. W. Powers of Topeka is in England attached to a general hospital. Major Don Wakeman of Topeka is also in England we have heard.

Major T. J. Sims of Kansas City has since December been the Chief of Surgery at the Third Air Force Regional Hospital at Hunter Field, Savannah, Georgia.

Then Major Robert H. Riedel of Topeka, now in the Army Air Force Headquarters of the Air Transport Command in Washington, has written to the Journal: "I appreciate receiving the Journal and therefore I would appreciate it very much if you would list my mailing address as above."

Lt. Clarence A. Gripkey of Kansas City writes: "Would appreciate your forwarding my copy of the Journal to the new address. Fleet P.O., San Francisco, California.

"Riding a Flying Ambulance"—the title of an abstracted letter from a Navy lieutenant published in the Rhode Island Medical Journal is worth reprinting. "The ship has been refitted as a flying ambulance and what a job she can do! . . . We were the first to fly in and evacuate casualties from a certain combat area while the fighting was still going on. We landed on the water and, wearing our tin hats, loaded forty-one patients aboard, keeping a wary eye on the goings on nearby. One couldn't suppress a comfortable feeling of warmth and a wry grin as he looked up occasionally to where the low hum of swarms of fighter planes could be heard protecting us. 'God bless the fighters' is never breathed so fervently as when you are sitting on the water loading wounded aboard! Then the takeoff . . . I am in the compartment with those most critically hurt. A sudden deep roar as the throttles open, the plane lurches ahead, bumping over the waves, ever more rapidly until a sudden lurch upward and the ride becomes very smooth. You know you are off the water. The engines roar on under full power for a few minutes until we gain altitude then they are throttled down to cruising speed. I have a corpsman with me. We check

each man—the nature of his injury and a quick examination reveals the attention he needs.

"Back and forth on the catwalk with my flashlight—one man wants water, another is white from loss of blood, and others want a cigarette. Now and then one needs plasma or morphine or maybe someone to help him smoke if he can't hold a cigarette himself. But with all the injured it's the same—you never hear a whimper or complaint. To them I'm just plain "Doc" and they know why I'm there.

"You can't describe these fighting men—and those whose fighting days are over. They are wonderful! They don't talk much—there is too much noise and, too, there's nothing to talk about. You don't try to be smart or flippant with them—nothing is very damned funny to them now. They don't complain. An hour or so ago, they belonged to the guns and tanks and planes—but now they are mine—they belong to the Medical Corps which exists only for them. They have done their job and have paid for their share in America—they and their buddies who aren't coming back in this big gray hospital plane.

"After everyone is cared for we can stop for a drink of water and a smoke. I look out the port and see a couple of fighters high overhead. One peels off and dives, pulling out at our level and cruises some distance alongside. The pilot raises his hands clasped like a handshake—wiggles his wings as a salute, then banks away to return to the battle. We don't need him any longer.

"When we get back 'home'—late that night there are many hands to help us. Several boats meet the plane with men to help unload. We are met on the ramp by the 'big shots' and plenty of ambulances. A few words of commendation, some questions about how things are going and then, after the patients have left in the ambulances, we carry our kits and helmets home, grab a snack and go to bed.

"This is my job—to do what I can (and sometimes it seems like so little) for these men. I can't describe them—their tired, dirty faces, scraggly beards, blood-stained bandages and the white faces looking to me for help. They and the thousands who are still fighting are nothing short of magnificent. I'm proud of my job and you and the people who have helped so much to give me the training I needed to do it."

Mrs. Thorpe of Wichita writes re-addressing her husband's issue of the Journal. Major George L. Thorpe has an APO address out of New York.

Recent War Department orders include: Dr. Morton Emmons Brownell, Jr., of Wichita promoted from lieutenant to captain in the Medical Corps.

Major Garth S. Ortman of Kansas City has been transferred from Albuquerque, New Mexico, to Glendale, California, and on to Fort Sam Houston, Texas.

Lt. Cecil Petterson of Norton has been transferred from Blythe, California, and now has an APO address out of New York.

Lt. Francis A. Thorpe of Pratt has been transferred from March Field, California, to Atlantic City, New Jersey.

Lt. Otis D. Swan of Topeka has been transferred from March Field, to Hammer Field, Fresno, California.

Major M. E. Pusitz of Topeka has been transferred from Modesto, California, to Ft. Lewis, Washington.

Major M. W. Hall of Wichita has been transferred from Nashville, Tennessee to Oxford, North Carolina.

Capt. Edward Greenwood of Topeka stationed at Camp Carson, Colorado, now has an APO out of New York.

Major Ralph L. Drake of Wichita has been transferred from Fort Leonard Wood, Missouri, and has an APO out of San Francisco.

Capt. Donald Eggleston of Kingman formerly in Tacoma, Washington, has a recent APO address out of San Francisco.

Lt. Cecil Petterson of Norton has been transferred from Hill Field, Ogden, Utah, to the Army Air Base at Blythe, California.

NEWS NOTES

DR. LATTIMORE ANNOUNCES FOR HOUSE OF REPRESENTATIVES

Dr. John L. Lattimore of Topeka, retiring President of the Society and its newly elected Treasurer, has announced his candidacy for the Republican nomination for Representative from the Thirty-fifth district in Shawnee County, which comprises the townships of Topeka, Tecumseh, Williamsport, Auburn, Dover, Mission and Monmouth, and the Fifth, Sixth and Seventh wards of Topeka. Dr. Lattimore is running in place of Mr. Allen Meyers, attorney who recently was appointed as the county attorney and does not plan to enter the race this year.

Dr. J. B. Carter of Wilson, Senator, recently entered the armed service as a lieutenant colonel in the Medical Corps and thus no member of the medical profession is now in either the Senate or the House of Representatives.

Dr. Lattimore is a good public speaker, and has frequently appeared in many towns in the state to discuss medical and health problems. He is a member of the Kansas State Board of Health, a Fellow of the American Medical Association, a Diplomate of the American Board of Pathology, served as President of the American Society of Clinical Pathologists in 1941 and 1942 and as President of the Society in 1943 and 1944. He served in the Medical Corps in World War I, is a Director of the Kansas Group Hospital Service, Inc. (the Kansas Blue Cross), a member of the Board of Regents of Washburn Municipal University and is the pathologist at the three Topeka hospitals. He is owner and manager of the Lattimore Laboratories in Topeka, El Dorado and in Sedalia, Missouri, and McAlester, Oklahoma.

DR. DECKER RE-ELECTED TO EDITORIAL BOARD

At a meeting of the Council held in Topeka on May 11, 1944, Dr. Ernest H. Decker of Topeka was re-elected as a member of the Editorial Board of the Journal of the

MAY, 1944 175

Kansas Medical Society. In 1943 Dr. Decker was elected to fill the unexpired term on the board of Dr. L. E. Eckles now in service as a lieutenant commander in the Navy. Dr. Eckles' term expired in 1944 and Dr. Decker has, therefore, been elected for a four year term.

Other members of the board are Dr. W. M. Mills, Editor and Chairman of the Editorial Board; Dr. L. R. Pyle, Dr. Don C. Wakeman and Dr. Robert Knight. Dr. Wakeman and Dr. Pyle are both in the military service at the present time where Dr. Wakeman is serving as a major in the Army over sea and Dr. Pyle is a lieutenant commander in the Navy.

DR. CLARA JOHNS TO BOARD OF HEALTH

Dr. F. C. Beelman, Secretary of the Kansas State Board of Health, announced on April 17 that Dr. Clara Johns, assistant surgeon (R.) of the United States Public Health Service had been secured as the acting Director of the Maternal and Child Health Division of the Kansas State Board of Health to succeed Dr. H. R. Ross who died recently. Dr. Ross had succeeded Dr. Fred Mayes the permanent director of the division who had resigned to accept a position with the United States Children's Bureau.

It is through this office that the work of the Emergency Management and Infant Care Program for service men and their dependents is conducted.

BOARD OF HEALTH MEMBERS RE-APPOINTED

Governor Andrew Schoeppel announced on April 15 the re-appointment of the following physicians as members of the Kansas State Board of Health: Dr. J. F. Gsell of Wichita, Dr. R. T. Nichol of Hiawatha and Dr. H. A. Hope of Hunter. Other members of the board are as follows: Dr. Geo. I. Thatcher of Waterville, Dr. H. L. Aldrich of Chaney, Dr. J. L. Lattimore of Topeka, Dr. G. A. Leslie of McDonald, Dr. F. L. Loveland of Topeka, Dr. Clyde D. Blake of Hays, and Mr. Reginald Glandon of Kansas City, the attorney member.

A. M. A. MEETING

The official call to the members for the ninety-fourth annual session of the American Medical Association which will be held in Chicago from Monday, June 12, to Friday, June 16, 1944, was recently received in the central office.

The house of delegates will convene on Monday, June 12, at 10:00 a. m., in the Red Lacquer Room of the Palmer House. The scientific assembly will open with a general meeting on Tuesday, June 13, at 8:00 p. m. and will include the following sections: Practice of medicine; obstetrics and gynecology; laryngology, otology and rhinology; pathology and physiology, orthopedic surgery; urology; preventive and industrial medicine and public health; anesthesiology; other miscellaneous topics; a session for general practitioners; surgery, general and abdominal; opthalmology; pediatrics; experimental medicine and therapeutics; nervous and mental diseases; dermatology and syphilology; gastro-enterology and proctology; and radiology.

TOWN HALL COMMITTEE

The following communication was received in the central office from Mr. Bliss Isley, publicity chairman for the

Town Hall Committee, which we believe is of interest to the membership:

"Now would be a good time for any doctor to read on page 62 of the May issue of Nation's Business an article entitled "Wichita Does Something." It is only 900 words long and it tells of the plans of the Town Hall Committee of Wichita, which is seeking to organize town halls in every city and rural community in the Unted States.

"This concerns every doctor opposed to the Wagner-Murray Bill. Up to now medical men have been fighting their battle alone. Likewise the cement men, the farmer, the restaurant owner, the lawyer, the industrialist—all have been fighting alone. And because we fight alone, the bureaucrats beat us in detail, just as they beat a certain big business man in Chicago by sending two soldiers to his place of business. They carried him out.

"Bureaucrats do not heed the Constitution. One high federal official has said in public address: "To hell with the Constitution!"

"The Town Hall plan proposes a union of all groups that are fighting for a return to Constitutional government. The Town Hall Declaration calls for a return to the states, the people and the local governments those non-federal powers that have been taken over by federal bureaus.

"Certainly nothing in the Constitution grants to the federal government the authority to socialize medicine. But you cannot prove that to a bureaucrat. We must prove it to Congress by amassing votes—not merely of the doctors but of all the people who are against aggrandisement of power by the executive branch of the federal government.

"Let the doctors of Kansas join with business men, with farmers, with others and take the lead in organizing Town Halls. Write to the Town Hall Committee, 510 Bitting Building, Wichita 2, Kansas, for a booklet containing the Town Hall Declaration of procedure."

DEATH NOTICES

Dr. Theodore Kroesch, 54 years of age, died by self administered poison at his home in Enterprise on April 5. He was graduated from the Rush Medical College in 1905 and was a member of the Dickinson County Medical Society.

Dr. Harry R. Ross, 75 years of age, of Topeka, died on April 10 as he was preparing to make a speech in the State House. Dr. Ross, director of Child Hygiene, of the Kansas State Board of Health with which he had been affiliated for the past ten years formerly practiced in Sterling. Born in Birmingham, Iowa, on April 23, 1869, he was graduated from the Medico-Chirurgical College of Kansas City in 1900 and was a member of the Shawnee County Medical Society.

Dr. William J. Scott, age 67, died on March 15 after an illness of several months at his home in Baxter Springs. Born on August 14, 1876, in Jameson, Missouri, he was graduated from the University Medical College of Kansas City in 1900. He was a member of the Cherokee County Medical Society.

Dr. Horace G. Welsh, 88 years of age, died on March 9 at his home in Hutchinson after a three year illness. He was born in Fostoria, Ohio, on October 1, 1855, and was graduated from the Jefferson Medical College of Philadel-

phia, Pa., in 1880. Before coming to Hutchinson Dr. Welch practiced in northeastern part of Kansas and in Sterling. He was an honorary member of the Reno County Medical Society.

COUNTY SOCIETIES

The Butler-Greenwood County Medical Society held a meeting in El Dorado on April 14 in Allen County Memorial Hospital. Dr. R. M. Sorensen, Director of Venereal Disease Control of the Kansas State Board of Health was the guest speaker.

The Central Kansas Medical Society held a meeting in Russel on March 30. Speakers from the Walker Army Air Field Hospital were: Capt. Howard Seitz who discussed "Ear, Nose and Throat and Aviation Medicine"; Capt. Sam Schneider who talked on "Burns," and Capt. Joe Siprin who discussed "Spotted Fever.'

The members of the Clay County Medical Society met for a steak dinner the evening of April 12 in Clay Center. The following were appointed on the county society publicity committee: Dr. W. R. Morton, Dr. G. W. Bale and Dr. F. C. Shepard. Dr. B. A. Nelson of Manhattan discussed the proposed Kansas prepayment plan.

The Golden-Belt Medical Society held a meeting in Junction City on Thursday, April 6. Dr. Herbert Rinkel of Kansas City, Missouri, conducted a symposium on "Hay Fever" assisted by Dr. Cecil M. Kohn also of Kansas City, Missouri, who discussed the "Diagnosis and Treatment of Hay Fever." Dr. Porter Brown of Salina spoke on "Some Don'ts in the Practice of Gynecology." The Geary County Medical Society was hosts for the meeting. Dr. E. M. Sutton of Salina was elected as the new president to succeed Dr. L. S. Nelson of Salina and Dr. G. E. Brethour of Dwight was elected as secretary-treasurer to succeed the former secretary-treasurer, Dr. E. M. Sutton.

At a meeting of the Pawnee County Medical Society the following officers were elected: Dr. Earl F. Morris of Larned as president and Dr. John A. Dillon of Larned as secretary-treasurer.

At a recent meeting of the Rice County Medical Society the following were elected to office: Dr. Herlan O. Loyd of Bushton as president; Dr. Jack C. Dysart of Sterling as vice-president; and Dr. George L. Gill of Sterling as secretary-treasurer. Delegates and board of censor members remained the same as last year.

The Sedgwick County Medical Society had as their guest speakers at their March 7 meeting: Capt. R. C. Kingsland from Camp Phillips who spoke on "Pneumonia" and Major J. Stewart McQuiston of Camp Phillips who discussed "Differential Diagnosis of Jaundice."

At the May 1 meeting of the Shawnee County Medical Society the following officers from the Topeka Army Air Base Hospital appeared on the scientific program: Lt. James Downey spoke on "Brodie's Abscess"; Lt. Bernard Kaye spoke on "Progressive Hemiatrophy of the Face" and Capt. Joseph Coock discussed "Polycythemia vera."

The speaker at the April 18 meeting of the Wyandotte County Medical Society, held in Kansas City, was Dr. Frederick H. Fall of the department of Obstetrics and Gynecology of the University of Illinois in Chicago. Dr. Fall discussed "Ectopic Pregnancy."

MEMBERS

The article "Screw Worm Infestation of the Ear" by Dr. Ralph Melton and Frederick W. King of Marion which was first published in the December, 1943, issue of the Journal was abstracted in the March, 1944, issue of the Digest of Ophthalmology and Otolaryngology.

Dr. Geo. C. Meek of Little River has recently returned home after completing a post graduate course in surgery at the Cook County Hospital in Chicago.

Dr. M. O. Steffen of Manhattan has recently completed a post graduate course in obstetrics at the Chicago-Lying-In-Hospital.

Dr. Orville S. Walters, president of Central College of McPherson, has announced his resignation of that position as of June 1. Dr. Walters has recently completed his internship at the Wesley Hospital in Wichita.

Dr. H. A. Hope of Hunter recently completed post graduate work in New York under the Commonwealth Fund.

Dr. Ralph I. Canuteson of Lawrence was elected president of the American Student Health Association at its annual meeting held in Cincinnati, Ohio, on March 15 and 16.

Dr. A. A. Krugg of Coffeyville is the author of a recently published book entitled "Facts and Fancies," drawn from the experiences and observations of a doctor of medicine with a half century of Kansas practice.

Dr. Earl F. Morris, formerly of Hays, has moved to Larned.

The 50th anniversary edition of the Medical Women's Journal paid special tribute to Dr. Emma L. Hill, formerly of Oswego, whose death occurred in 1943 as a result of an automobile accident while attending a patient.

A FORWARD STEP

Out in the Midwest during the month of August an important conference was arranged in which members of Congress and their constituents, representing farming, retail business and the professions, participated. Among the groups represented was the Minnesota State Medical Association. Some twenty-five Senators and Congressmen accepted invitations to be present. As might be expected, the Wagner-Murray-Dingell bill came up for discussion, which, it was reported, was very frank.

In the opinion of this observer, groups in this section of the country might well follow the lead of their Midwestern colleagues. For only through a frank exchange of views will our legislators have an intelligent understanding of the problems confronting their constituents and how they can best serve them.—Medical Annals of the District of Columbia.

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OFFICIAL PROCEEDINGS

TO: THE HOUSE OF DELEGATES:

The Executive Secretary's report will of necessity be curtailed because of the fact that the Society has been without a regular secretary since the resignation of Mr. Robert A. Brooks on January 9. However, I shall attempt to give a brief resume of the activities of the central office through the year.

In addition to the routine collection of membership dues, mailing out membership cards, etc., the central office collaborated with the Extension Division of the University of Kansas and the Kansas State Board of Health in organizing and sponsoring a series of three post-graduate medical clinics held in five cities, Kansas City, Parsons, Wichita, Salina and Emporia. The first of this series was on tropical diseases, the second on diseases of the chest and the third on cardiac disorders. These clinics were well received and well attended.

In June of last year, the Society also cooperated with the Kansas State Board of Health in presenting an institute of wartime industrial health. There were two such meetings, one in Kansas City and one in Wichita. Speakers were secured representing the War Manpower Commission, labor, management, industrial commissions, industrial physicians, medicine, the State Board of Health and the American Medical Association. These, also, were satisfactorily attended.

A critical situation arose in connection with the handling of narcotics by the hospitals of Kansas. A special meeting of officers and councilors was held in Salina, with several other physicians from key locations being invited. Conferences with Mr. Bell of the Federal Bureau of Narcotics resulted in a satisfactory compromise.

Probably the most talked about project which the Society has undertaken this year is the Emergency Maternal and Infant Care Program established by the United States Children's Bureau. After the initial program was endorsed by the Council and by the Child Welfare and Maternal Welfare Committees, Congress introduced a clause into the bill, prohibiting any discrimination against anyone licensed by the state to participate in the program. This called for a vote of the Council, which was obtained by mail. The Council voted to continue the program, although not heartily in accord with all its policies. A local committe was set up for administering this program, consisting of Dr. P. E. Belknap, Dr. F. L. Loveland, Dr. Ray A. West, Dr. J. L. Lattimore, Dr. H. R. Ross and Dr. F. C. Beelman. This committee has worked very closely together and there has been fine cooperation between the Board of Health who administer the program through the state, and the state Society. Dr. Fred Mayes handled the program for the Board of Health until his transfer to another post, when Dr. Ross took over. At his death, Clara Johns, Assistant Surgeon (R) USPHS, was appointed as acting director. In connection with this program, communications have been received at the central office in recent weeks describing resolutions which have been passed by the council of the Minnesota State Medical Association and the council of the Chicago Medical Society, expressing disapproval of the conduct of the Children's Bureau and recommending the discontinuance of this program at the expiration of its date, June 30; also recommending that in the future the benefits be designated supplemental aid and take the form of allotments for medical, hospital, maternity and infant care, leaving the actual arrangements with respect to fees to be fixed by mutual agreement between the enlisted man's wife and the physician of her

Printed cards setting forth "standards of obstetrical care" compiled by the Committee on Maternal Welfare have been sent out from the central office to the complete membership on three different occasions.

Publicity and information have been disseminated concerning the Wagner, Murray, Dingell bill. A poster entitled "Your Doctor and the War" was designed and mailed to every member in the state. Early in the fall of 1943, a small campaign was launched, designed to interest delinquent members in reinstating themselves in the Society.

Your President requested Dr. B. A. Nelson, chairman of the Medical Economics Committee, to make a study of the progress other state societies have made in establishing physicians' medical service as an answer to socialized medicine. Considerable research was conducted by the central office to aid Dr. Nelson in this study.

Every assistance possible was given to Dr. Loveland, state chairman of Procurement and Assignment until he was allowed funds for a full time secretary. Since that time, the central office has offered what help was needed.

In February, 1944, your acting scretary attended a twoday meeting of the Health Committee of a Post-War Planning Committee held in Manhattan and sponsored by the Extension Division of Kansas State College.

Although the method of examining inductees has been changed within the last few months and the need for examiners is not so great, the central office has continued to work with Lt. Col. Seth A. Hammel in obtaining the voluntary services of these men when needed.

The Kansas State Board of Health has been helpful at all times and has worked closely with the central office in maintaining an up to date roster of Kansas physicians, both members and non-members.

Mrs. Rosaleigh Barney was employed for several months but left in January to join her husband in the armed services. The services of Miss Millie Neel were obtained soon after and she has proved to be very helpful and loyal. Mrs. Todd has continued in her capacity as business manager of the Journal.

I cannot say enough in praise and gratitude for the assistance of your president, Dr. Lattimore. He has never been too busy to listen to questions and to offer his wise and generous counsel. I feel grateful for the trust and confidence you have placed in me and hope it has not been misplaced.

At the present time we have 1,112 paid and honorary memberships with less than a hundred one-year delinquents, and about 380 service members.

GENERAL FUND

Salaries:		
Regular	\$6,416.67	
Extra	45.25	
	 \$	6,461.92
Office Rental		540.00
Telephone & telegrapl	h	645.45
Postage & express		451.06
Stationery, supplies &	equipment	1,186.53
		1,406.23
Committee expense .		406.16
Social Security		64.62

Procurement & Assignment

Miscellaneous

41.09

616.57

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In war, even more than in peace... dispenser of blessed relief... his the precious power over pain.

Long hours the medical officer toils... routinely yet heroically... without thought of citation... grateful for brief moments of relaxation... for the cheer of an occasional smoke. And likely as not, his cigarette is Camel, the favorite brand in the armed forces*... first choice for smooth mildness and for pleasing flavor. It's what every fighting man deserves... that extra measure of Camel's smoking pleasure.



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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division ,One Pershing Square, New York 17, N. Y.

DEFENSE FUND Retainer fee 900.00 Expenses 95.05

\$12,814.68

Respectfully submitted
Margaret R. Foster
Acting Executive Secretary

TO: THE HOUSE OF DELEGATES:

The Editorial Board of the Journal of the Kansas Medical Society wishes to submit the following report for the period from May 1, 1943, to May 1, 1944:

JOURNAL FINANCIAL REPORT

Assets:	
Cash in the bank \$2,148.84 less April vouchers	\$1,765.06
April advertising. Accounts receivable	. 504.30
Post office deposit, stamps on hand	. 54.56
Paper stock on hand	. 163.90
SURPLUS	.\$2,487.82
INCOME:	¢ (0.00

Subscriptions	and single	copies of	Journal	69.09
Advertising .				6,556,65
			_	

	\$6,625.74
EXPENSES:	Ť
Printing	\$3,116.11
Engraving	
Postage	275.00
Salary	
Taxes (Social Security & Withholding)	193.10
Misc., travel, stationery, bonds, etc	151.90
Paper stock used during the year	

\$6,076.96

PROFIT\$ 548.78

Respectfully submittel

W. M. Mills, M.D.

Chairman, Editorial Board

The following amendments to the By-Laws were adopted individually:

(Extract from report of second meeting of House of Delegates at Topeka, May 11, 1944)

CHAPTER I, Sec. 4. Members of this Society may be enrolled as honorary members upon the certified recommendation of the component societies to which they belong. Such recommendation shall be based upon years of faithful service in the medical profession, or upon other grounds acceptable to the Council. Honorary members shall be entitled to all of the benefits and privileges of active members, but shall be exempt from the payment of assessments.

Honorary members having qualifications required by the Constitution of the American Medical Association may be recommended for Affiliate Fellowship in the American Medical Association by vote of the House of Delegates.

CHAPTER V, Sec. 17. The following is substituted for the original section. "Representatives to the House of

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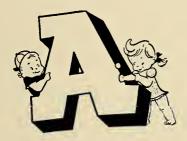
Ralph Emerson Duncan, M.D. Director

529 Highland Ave.

e. Kansas City, Mo. Telephone—VIctor 4850

Registered by the Council on Medical Education and Haspitals of the

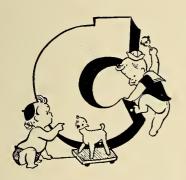
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Delegates of the American Medical Association shall be certified to each annual meeting of that body according to the Constitution and By-Laws of that association, and shall be selected in the following manner: one-half the number of Delegates permitted this society for two year terms of office shall be selected annually as Delegates-Elect, whose term shall begin with the annual session of the American Medical Association of the year succeeding their election.

CHAPTER V, Sec. 8. The following is substituted for the original section: "The official order of business for the first session of the House of Delegates, unless otherwise ordered by a two-thirds vote of the Delegates present, shall be:

- 1. Registration of Delegates and ex-officio members of the House and visitors.
 - 2. Call to order by the President.
 - 3. Reading of the minutes of the last meeting.
- 4. Announcement of the number of Delegates and exofficio members registered and the presence of a quorum.
- 5. Report of Reference Committee with summarized data on reports of:
 - a. Councilors
 - b. Standing Committees
 - c. Special Committees
 - d. Resolutions submitted
 - 6. Report of Defense Board
 - 7. Report of Editorial Board
 - 8. Report of Executive Secretary
 - 9. Report of Constitutional Secretary
 - 10. Report of Treasurer
- 11. Report of American Medical Association Delegates
- 12. Message of the President
- 13. Message of the President-Elect
- 14. Unfinished business

- 15. New business
- 16. Announcements
- 17. Adjournment

The official order of business for the last meeting of the House of Delegates at each annual session shall be:

- 1. Registration and seating of Delegates, ex-officio members and visitors
 - 2. Call to order by President
 - 3. Report of secondary meeting of Reference Committee
 - 4. Unfinished business
- 5. New business (except for authorization of proper bills, must be authorized by consent of two-thirds majority of Delegates to the session)
 - 6. Election of officers:

President-Elect

First Vice President

Second Vice President

Constitutional Secretary

Treasurer

Delegate-Elect to American Medical Association

- 7. Election of Councilors for expired terms by caucus of Delegates present from the respective districts.
- 8. Announcement of Councilors elected and meeting place of the Council.
 - 9. Installation of the new President
- 10. Adjournment

CHAPTER XI, Sec. 1. The following is substituted for the original section: Section 1, shall be amended to read as follows:

"Regularly appointed committees of this Society shall be of three classes:

a. Standing Committee whose work continues from year to year. These are:

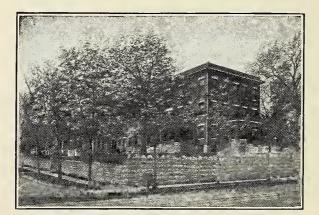
Committee on Allied Groups to Medical Practice

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HERMON S. MAJOR, M.D. Medical Director

HENRY S. MILLETT, M.D. Associate Medical Director

HERMON S. MAJOR, JR. Business Manager

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The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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Committee on Arrangements

Committee on Auxiliary

Committee on Child Welfare

Committee on Conservation of Eyesight

Committee on Conservation of Hearing

Committee on Constitution and Rules

Committee on Control of Cancer

Committee on Control of Tuberculosis

Committee on Credentials

Committee on Endowment

Executive Committee of the Council

Committee on Study of Heart Disease

Committee on History

Committee on Hospital Survey

Committee on Maternal Welfare

Committee on Medical Economics

Committee on Medical Schools Committee on Necrology

Committee on Public Health and Education

Committee on Public Policy

Committee on Scientific Work

Committee on Stormont Medical Library

Committee on Venereal Disease

b. Special reference committee or committees on reports of Councilors, committees, and other reports deemed by the President subject to condensation.

c. Special or temporary committees.

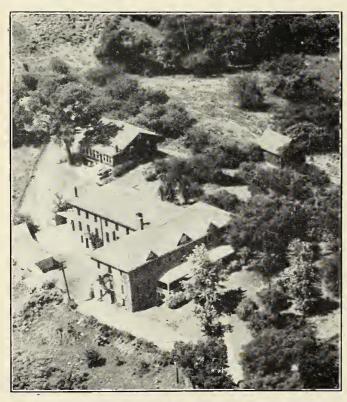
CHAPTER XI, Sec. 2. Remains as in the original and the following paragraph is added: "A special reference committee to consist of at least three members shall be appointed two weeks or more before each annual session."

CHAPTER XI, Sec. 3. Is deleted and the following

substituted: "Each standing committee or special committee shall submit to the Executive Secretary a written report in duplicate, addressed to the House of Delegates, not later than six weeks before each annual session, the same to be printed in the Journal or a handbook for distribution to the membership for information and consideration prior to the annual meeting, and shall submit such additional reports as the House of Delegates or the Council may require.

The special reference committee shall study the reports of standing committees, special committees, Councilors, and other reports deemed by the President as worthy of condensation, as well as any resolutions to be offered to the House of Delegates, and submit concise and summarized statement of the work of the year as shown in the individual reports, before individual or collective adoption by the House of Delegates as a part of the record. Resolutions presented shall be duly considered and recommendations made for their adoption or rejection. The committee report shall be submitted at the first meeting of the House, and if deferred action on such recommendations is deemed advisable, the committee shall hold subsequent open meetings for hearings on the subject before final action is taken at the last regular meeting of the House of Delegates."

CHAPTER XI, Sec. 28. Is added: "The Committee on the Study of Heart Disease shall consist of at least five members. It shall be the duty of this committee to conduct study and research on the study of diseases of the heart, and circulatory diseases affecting or originating from the heart, and to disseminate information on these subjects to the component organization of this Society, to the medical profession in general and to the public when lay education is desirable. A portion of its retiring members, and when-



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MAY, 1944



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ever practical, the retiring chairman, shall be included in its membership."

CHAPTER XI, Sec. 29. Is added: "The Committee on Conservation of Hearing shall be composed of at least five members. It shall be the duty of this committee to conduct study and research on the subject of conservation of hearing, and diseases affecting the otic organs and to disseminate information on these subjects to the component organizations of this Society, to the medical profession in general, and to the public whenever lay education is desirable. A portion of its members, including the retiring chairman, whenever practical shall be included in its membership."

CHAPTER XII, Sec. 5. Is deleted and the following substituted: "Each component society shall judge the qualifications of its own members, but as these societies are the only portals of entrance to this Society and to the American Medical Association every reputable and ethical physician having a degree of Doctor of Medicine from an accredited medical school and licensed by the Kansas State Board of Medical Registration and Examination, legally registered in his county of practice shall be privileged to apply for membership. Before a charter is issued to any component society full and ample notice and opportunity to become a member shall be given to every physician in that county who is eligible as herein provided."

The Amendment to Chapter I providing for Associate Membership in the State Society was defeated by vote of the House of Delegates.

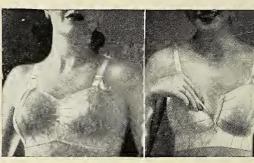
Amendment to Chapter V, Sec. 17—A clause providing for limitation of tenure of office of Delegates to the American Medical Association was defeated by vote of the House of Delegates.

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SAYS PROGRESS OF PHYSICAL MEDICINE WILL BE FURTHERED BY BARUCH GIFT

Commenting on an announcement of a gift of \$1,100,000 given by Mr. Bernard M. Baruch, of New York, to be used for teaching and research in physical medicine, The Journal of the American Medical Association for April 29 says:

"Physical medicine includes, under the definition of this gift, the treatment of disease by extensive physical agents, including light, water, heat and electricity as well as by exercise and massage. Mr. Baruch appears to have been stimulated particularly to make his gift now because of the indications that physical therapy will be able to do much for the rehabilitation of the wounded and disabled who are already being released from the armed forces and who are likely to come with increasing numbers as the invasion goes on.

"For some time a well qualified committee, headed by Dr. Ray Lyman Wilbur, has been studying the technic of approach to proper use of the funds which Mr. Baruch has now made available and which will no doubt be greatly supplemented in the future. Dr. Simon Baruch, distinguished father of Mr. Bernard Baruch, was himself a pioneer in this field. His name is associated with much of the progress that has been made, particularly in New York State. . . .

"Thus the committee has recognized the basic importance of sound education and research to further progress in this field as in other fields of medicine. No doubt the work will be extended to some of the well recognized spas and health resorts of the United States, concerning which such excellent reports have recently been made available by the

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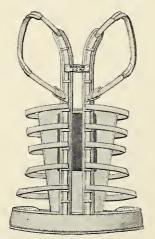
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2-149-154.

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INADEQUATE DIETS AND NUTRITIONAL DEFICIENCIES IN UNITED STATES

The Committee on Diagnosis and Pathology of the Food and Nutrition Board of the National Research Council has reviewed material reported in widely scattered journals on the state of nutrition of the people of th United States. An appreciable percentage of diets fail to meet more than fifty per cent of the recommended daily allowances of the Food and Nutrition Board, but many more diets are deficient by less than fifty per cent, emphasizes The Journal of the American Medical Association for April 15. This widespread prevalence of more or less deficient diets is associated with a high incidence of deficiency states, largely mild in intensity and gradual in its course. The problem thus created is both preventive and corrective. For prevention, production of sufficient food must be maintained and better distribution is required; judicious enrichment of appropriate foods may be advisable, and dietary education should be intensified and extended. For correction there is need for skill in detecting deficiency conditions and improved procedure for the treatment of such conditions. There has been some exaggeration of the benefits of optimal nutrition and much exploitation of the vitamins. This has retarded the proper application of the science of nutrition. However, knowledge of the relation of nutrition to health is being rapidly uncovered. The evidence now available, incomplete though it may be, leads to but one conclusion: that "there is a real difference as measured in terms of growth development and general health record between optimum and just adequate nutrition; and that every practical effort should be made to apply this knowledge in the interest of human welfare.'

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MAY, 1944 191

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KANSAS MEDICAL ASSISTANTS' SOCIETY

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	Mary Nicholson, Winfield
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Fifth Dist. Councilor	Lois Clopper, Dodge City

Th annual meeting of the Kansas Medical Assistants Society, held in Wichita on May 12, was a great success. Total registration was 105, which it is believed was more than originally anticipated, and the program printed in the

Journal for April was changed in one respect. At 10:30 Mrs. C. A. Clark of Wichita, gave a talk on "Blood Plasma and Other Major Programs." Mr. Oliver Ebell, executive secretary of the Sedgwick County Medical Society and newly elected executive secretary of the Kansas Medical Society, gave an interesting talk on "The Doctor and His Assistant."

The Lyon County Medical Assistants Society held a meeting in Emporia on March 7, at the home of Miss Claudia Williams. Miss Shirley Thomson reviewed the book "Taps for Private Tussey," by Jessie Stewart. The mothers of the members were guests at the meeting and ten were present.

The Sedgwick County Medical Assistants Society held their regular meeting at the Hotel Allis on April 19. Mr. George Fooshee of Wichita, talked to the members on the "Medical Credit Clinic." The March 15 meeting was a joint one with the Wichita Dental Assistants.

The Shawnee County Medical Assistants Society were entertained by the office force of the Shawnee County Medical Society with a buffet supper at the county society rooms on April 4.



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Some 300,000 beds will be needed to enable veterans of this war to receive hospital and domiciliary care to the extent provided veterans of other wars, according to a statement released to The Modern Hospital on November 14, 1943, by Brig. Gen. Frank T. Hines, administrator of Veterans' Affairs.

This estimated maximum, however, should not be required until long after the war. It will necessitate the eventual additional construction of not more than 100,000 beds, because, as General Hines pointed out, under present plans there will be 100,000 beds in Veterans Administration facilities, and it should be possible to obtain at least that many more beds from the Army and Navy shortly after the war terminates when these agencies have completed their medical and surgical treatment of the wounded.

Some 15,000,000 veterans will have the right after the war to be hospitalized by the Veterans Administration when beds are available, declared General Hines.

At the present time, the Veterans Administration has 66,305 hospital beds in its ninety-three facilities and is utilizing 2,859 beds in other government and contract hospitals. This number will be increased to approximately 87,000 under presently approved or contemplated construction programs. In addition, the Veterans Administration had space for 17,464 beds for domiciliary care, of which 9,466 were occupied on November 4.

From December 7, 1941, to September 30, 1943, a total of 26,000 veterans of the present war had been hospitalized by the Veterans Administration. Of that number 7,800 remained under care on September 30, with more than 17,000 having been discharged as recovered, improved, or arrested.—Eva Adams Cross, in the Modern Hospital.

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MAY, 1944 195

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PRESIDENT'S MESSAGE

"Perfection consists not in doing extraordinary things but in doing ordinary things well."

This is the theme song your president presents to you this year. The annual convention in Topeka as guests of the Woman's Auxiliary to the Shawnee County Medical Society is over, and we have returned to our homes with pleasant memories of our gracious hostesses and the pleasure of meetin old friends from all over the state again. Considering transportation difficulties we had a nice Auxiliary registration and I am sure everyone who attended the convention gained some worthwhile information.

The tea at the Governor's mansion was delightful and we all agree that Mrs. Schoeppel is a charming and beautiful hostess. The banquet as guests of the Kansas Medical Society made us fully realize the privilege of Auxiliary membership.

The last day of the convention, the general business session of the Auxiliary took place, officers were elected and installed and our capable presdent, Mrs. E. E. Tippin, joined the ranks of the past presidents, a group in which it is a privilege to be a member. The luncheon which was most attractive followed the business session. After short talks by Mrs. E. E. Tippin, Dr. J. L. Lattimore, and Dr. C. Omer West, the gavel was presented to me and then I fully realized the responsibilities attached to my office. It will be my purpose to serve the Auxiliary as president in a manner in keeping with the traditions and ideals of the capable leaders who have preceded me. I shall avail myself of every opportunity to serve you in the same spirit, I in turn will ask you to serve. All our efforts will be concentrated on the individual physicians wife asking her these three questions—(1) are you a member of an organized Auxiliary, or a member at large? (2) Do you subscribe to the National Bulletin, the official magazine of the Auxiliary

which is published four times a year for \$1? (3) Have you made Hygeia available by placing two or more subscriptions in places accessible to the lay reading public? If each physician's wife, widow or mother in the state of Kansas would fulfill the three requests listed above, our state and county program would reach its goal. We would have an informed membership and an informed laity.

As the post-war plans of the American Medical Association develops, there will be innumerable places where the Auxiliary members can come to the aid of the medical profession and find new outlets for service. New legislation is annually being proposed which would change the nature of medical practice in the United States. In all these movements, the Auxiliary will be able to exercise a great influence not only by membership in the Auxiliary but by your affiliations with other organizations. Let us be ready for these developments, by consulting your local county president or your state president.

On the radio recently, I heard this definition for success "Whenever everyone else walks, you run." Can we run this year and reach our goal? The poster presented during my luncheon address will be on the Auxiliary page this fall showing our progress by counties. I wonder who will be 100 per cent first and let my head emerge from the waste basket?

As an Auxiliary do you realize the Medical Society really appreciates us? This morning a note from Dr. Lattimore informed me that the Medical Society council voted \$100 to the Auxiliary to be used as we wish, to further our aims. Let us prove ourselves worthy of this generous thought.

The pledge adopted last year at the national meeting expresses our aims. "I pledge loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals.

I will be with you on paper in the June issue. I am anxious to know how many read the Auxiliary page. Will you spend a penny and send me a card?

Mrs. Leo. J. Schaefer

AUXILIARY NEWS

The Women's Auxiliary to the Wyandotte County Medical Society met on April 14, at the home of Mrs. J. H. Luke in Kansas City. Assisting hostesses at the one o'clock luncheon were: Mrs. J. H. Rabin, Mrs. Frances Nash, Mrs. J. G. Evans, Mrs. Hughes Day, Mrs. Glen Peters, Mrs. Stanley Laing, Mrs. E. DeVilbiss, Mrs. J. A. Burger and Mrs. K. C. Haas. Mrs. E. R. Millis sang a group of songs accompanied by Mrs. L. B. Gloyne and Miss Martha Logan from Swift and Company gave a most helpful talk on "Meat Cookery." The Auxiliary was honored by having Mrs. Ernest Tippin of Wichita, the Auxiliary President as a guest. Other out of town guests were: Mrs. Leo Schafer of Salina the President-Elect, Mrs. C. D. Blake of Hays the Vice-President, Mrs. M. A. Brawley of Frankfort the Second Vice-President, and Mrs. H. L. Regier of Kansas City the Secretary, Mrs. E. C. Duncan of Fredonia, Mrs. E. J. Nordurfth of Wichita, Mrs. Frank Coffee of Hays, Mrs. T. D. Blasdel of Parsons and Mrs. R. W. Urie of Parsons, who are all Past Presidents of the Auxiliary.

At the March 13 meeting of the Women's Auxiliary to the Sedgwick County Medical Society held in Wichita, Mrs. E. E. Tippin of Wichita, President of the State Auxiliary, was the honor guest. In a recent report of one meeting at the Red Cross rooms this group in one week rolled 1,800 one-inch bandages. Many of the members work in the Red Cross rooms on other than the usual meeting days.

THE JOURNAL

of the

KANSAS MEDICAL SOCIETY

Owned and Published by The Kansas Medical Society

Volume XLV

JUNE, 1944

Number 6

MANAGEMENT OF ACUTE INFECTIOUS DISEASES IN CHILDHOOD*

Archibald L. Hoyne, M. D.

Chicago, Illinois

Three major problems may be considered in connection with our subject. First, the possibility of active or passive immunization against the disease involved; second, the choice of therapeutic measures to be instituted, and third, the question of home or hospital care. In all three of these instances many of the difficulties of former years have been simplified because of the prevailing tendency toward lowered virulence of infecting organisms, additional and improved methods for immunization, and a broader knowledge of the public in respect to disease.

Smallpox and diphtheria lead the field among the acute infectious diseases which can be prevented with almost absolute certainty by means of active immunization. They differ, however, in one essential particular in respect to susceptibility. Whereas the average child at birth is vulnerable to an attack of variola, most new-born infants are immune to diphtheria. Consequently, the periods of life when defensive procedure should be invoked are not the same. Vaccination against smallpox may be done at three or four months of age, if the child is in good health. In case of exposure there is no contraindication to vaccination at any age. The constitutional reaction is less in the very young than if the primary vaccination is postponed until school age or later. For this procedure, inoculation is best performed by the multiple pressure method. Since the diphtheria antitoxin which most children possess at birth is gradually eliminated toward the end of the first year, we usually find it advisable to resort to active immunization at about nine months of age. For this purpose alum precipitated diphtheria toxoid is satisfactory or it may be combined with alum precipitated tetanus toxoid, a plan which is preferable. In this latter manner, not only is the patient protected

*Presented before the meeting of the Kansas State Medical Society, Topeka, May 10, 1944.

against two diseases at the same time with fewer injections but there is a greater antigenic response to each toxoid when given in combination than to either one administered separately.

Whooping cough is another important disease which is sometimes a cause for serious concern in early childhood as well as during infancy. We are well aware that pertussis now accounts for more deaths than all other common contagious diseases combined. Unlike diphtheria, measles, and scarlet fever, it is not uncommon for whooping cough to occur in early infancy, and unlike smallpox it is not possible to establish artificial immunity to pertussis during the first few weeks of life. As a consequence of these facts, high mortality rates for whooping cough are much more difficult to overcome than in the case of other diseases for which an immunizing agent is available.

Because there is insufficient antigenic response during the first half year of life, vaccination against pertussis is not undertaken until after six months of age. If Sauer's vaccine is used the dosage now recommended is 1 cc., 2 cc., and 3 cc. at three to four week intervals, making a total dose of ninety billion organisms. This vaccine is now obtainable in combination with diphtheria toxoid and also a triple antigen including tetanus toxoid. When these three agents are given simultaneously the results of immunization are claimed to be equally as good as when the antigens are administered separately. Moreover, reactions are said to be no more frequent or severe with such a combination. If this form of active immunization is undertaken at nine months of age it is ordinarily effective in the case of diphtheria and tetanus prevention. However, nothing has been accomplished in protecting the infant from whooping cough during the first year of life, a period when fatality rates are highest, because approximately four months are required to establish immunity.

Human convalescent or hyperimmune pertussis serum might be used for passive immunization. But neither of these serums is easily obtainable, and so artificial means for affording immunity to pertussis continue to be unsatisfactory or difficult to achieve.

Against measles there is no artificial means of

bringing about active immunization. For passive immunization human convalescent measles serum in doses of 3.5 to 5 cc. if given within three days of exposure will, as a rule, afford temporary protection. Pooled adult serum or whole blood in 20 to 30 cc. doses is less reliable when used for the same purpose. Immune globulin has been less dependable for prevention, in our experience, than for modification of measles. For active treatment we have used amidopyrine during the past years. We continue to believe that excellent results are obtained with this drug and have never witnessed any harmful action from its administration.

Many times we have expressed the belief that if tonsils and adenoids were removed before children entered school there would be far less scarlet fever. This opinion is not based on the theory that immunity would be greater but that there would be fewer scarlet fever carriers to transmit the disease. Even if the child is immunized according to the Dick method it may become a carrier of hemolytic streptococci which are capable of producing scarlet fever. Moreover, a Dick negative individual is not free from attack by hemolytic streptocci from a scarlet fever patient even though no rash occurs with the infection. Passive immunization may be established either by human convalescent scarlet fever serum in 10 cc. doses intramuscularly or by scarlet fever antitoxin, if one of these measures is adopted within twelve hours of exposure. In either instance protection is likely to endure only for ten days to three weeks at most. The prevailing form of scarlet fever is now so mild that the necessity for specific therapy seldom seems indicated in hospital cases. Nevertheless, severe and unusual complications sometimes develop when least expected. Therefore, it is advisable often not to deny the patient any possible advantage which serum may provide.

There is no reliable method for immunization against chickenpox, mumps or German measles, although convalescent serums have been used. Even if there were a preventive for mumps it would probably be better for the exposed child to have the disease than to risk acquiring it after puberty.

Although chemotherapy is now adopted for almost all forms of acute infections, the chain of the common contagious diseases benefitted by early administration of the sulfonamides is not of great length. Most spectacular in responsiveness to the sulfa drugs is meningococcic meningitis, and favorable action is observed in almost all other forms of meningitis with exception of tuberculosis. Erysipelas is another outstanding example of a disease subjugated by chemotherapy and is one of the first of the acute infections which served to demonstrate the value of sul-

fanilamide. For many years our average fatality rate for erysipelas approximated ten per cent at the Cook County Hospital; now it is sometimes less than two per cent.

We have been unable to determine that the administration of sulfathiazole or some of the other sulfa drugs are of special value in uncomplicated chickenpox, whooping cough or measles. For the toxemia of scarlet fever we feel convinced that nothing is gained by the use of these drugs. In respect to diphtheria, there are probably few clinicians who would have the temerity to use any sulfa drug as a substitute for diphtheria antitoxin. Nevertheless, in every one of these diseases with the exception of diphtheria, it is a common practice to resort to chemotherapy. Moreover, it is easy to understand that if some of these sulfa drugs are of definite value in the treatment of complications they might be expected to prevent those complications if prescribed sufficiently early in the course of the disease. But in our experience there has been insufficient evidence to support such a theory. On the other hand, reports from Army medical officers seem to have established that sulfa drugs have a prophylactic value when administered to meningitis contacts. The choice of the drugs even for this purpose alone, if efficient, is a worthy accomplishment. It would tend to justify the routine use of sulfa drugs early in the course of some of the acute infectious diseases previously mentioned. But during 1943, at Municipal Contagious Disease Hospital there were treated 187 patients with meningococcic meningitis. In that year there were 400 student nurses, who served in groups for periods of eight weeks each, who came in close contact with those patients. At the Cook County Contagious Disease Hospital last year we treated 169 meningococcic meningitis patients, and approximately 400 student nurses were concerned with their care. In each of these hospitals numerous employes including resident physicians, internes, graduate nurses, ambulance attendants, maids, and several hundred medical students came in contact with the patients. No sulfa drugs were used for prophylaxis; no face masks were worn, and not a single case of meningitis developed among the contacts in either hospital. This seems more remarkable when it is considered that the incidence for the disease was high in the city and, consequently, it would not have been strange if some of the hospital contacts had acquired a meningococcic infection from a source outside the hospital.

Notwithstanding the lack of enthusiasm expressed previously in regard to the prophylactic usage of sulfa drugs, it seems to me we should not be too critical of the procedure. If the drug does no harm there is at least a possibility that it may do some

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good as a protective measure when there is exposure to infection.

In smallpox, if sulfanilamide is administered during the stage of invasion the eruption may be aborted. We have not had an opportunity to demonstrate a similar action in respect to chickenpox.

Our experience with the sulfonamides has lead us to believe that chemotherapy is of the utmost value in erysipelas and nearly all forms of bacterial meningitis with the exception of tuberculosis. Also we have found the sulfa drugs useful in treating many of the complications of the acute infectious diseases, especially those which are deep seated. Blood stream infections respond well and there is no doubt in respect to efficiency of these drugs in cases of pneumonia. Sinus infections, including the ethmoiditis of scarlet fever, are favorably influenced. The action of the drugs on cervical adenitis, oritis media, and mastoiditis is not always easily determined and their effect in cases of nonsuppurative arthritis is doubtful.

Eventually we may find that penicillin will be the choice for many conditions where the sulfonamides now reign supreme.

Sometimes it is necessary to decide whether or not the contagious disease patient should be confined in an isolation hospital. This is a problem which is limited chiefly to the larger cities which maintain special hospitals for acute infectious diseases. Primarily, such institutions were originally established for the purpose of controlling epidemic diseases. By means of hospitalization which permitted rigid quarantine restrictions it was felt that foci of infection were removed from the midst of the community and thus danger of the spread of a particular disease was lessened. The term "pest house' was often applied to such institutions in the past and for many years there were numerous contagious disease hospitals which deserved no better designation. Such hospitals were inadequately equipped and sometimes poorly conducted. Much more thought was given to the isolation of patients than to the treatment of the disease from which they suffered. Today the better grade isolation hospitals are as well equipped as non-contagious disease institutions.

Notwithstanding the number of acute infectious disease hospitals in London, it was found some years ago that scarlet fever could not be controlled by hospitalization. Moreover, if it were possible to accomplish such a feat in the presence of an impending epidemic it would be a most expensive undertaking. All very mild cases as well as those which were severe would have to be admitted to hospital. But most of the carriers would be undetected and so continue at large. And we know that only a small percentage of scarlet fever patients give histories of contact with known cases of the disease. Conse-

quently, it is generally admitted by those who have made a study of the subject that scarlet fever in a large city cannot be controlled by hospitalization. In a small community an isolation hospital might better limit the spread of contagion because the sources of infection are likely to be more easily disclosed and the number of patients requiring isolation would probably not exceed the hospital's capacity.

Acute infectious disease patients should be hospitalized only for the same reason that other ill patients are hospitalized; namely, that they require some special care that a hospital alone is able to provide. With the better knowledge in respect to the common contagious diseases which the general public now has, most children with acute infectious diseases can be cared for in their own homes. Moreover, the assembling of large numbers of children with different diseases in the same institution must necessarily present certain hazzards regardless of the efficency of the hospital.

We believe the days of the large contagious disease hospitals in big cities are passing. The cost of maintaining such institutions at public expense is not justified. Unless admissions are properly controlled such hospitals are likely to be overcrowded during the cold season and almost empty in the summer months. The chief value of public isolation hospitals in large cities is an educational one. Student nurses and medical students are taught the principles of medical asepsis, diagnosis and treatment in the care of the common contagious diseases. Similar instruction could be given if every hospital was required to have a small isolation unit. Fear in respect to the common contagious diseases which is usually apparent on the part of hospital authorities can generally be attributed to lack of knowledge. With proper aseptic technique there should be practically no danger of spreading infection if such diseases as poliomyelitis and meningococcic meningitis were treated in a general hospital. Furthermore, if an isolation unit were maintained any of the acute infectious diseases could be cared for. In some of our states it is necessary to transport patients from 100 to 200 miles because nearby hospitals will not accept contagious disease cases. Unfortunately, the word "contagious" continues to inspire fear among many who profess to have modern minds.

3026 S. California Avenue.

A former infants' hospital in London, redesigned by American engineers and rebuilt by the British Ministry of Works, has been acquired by the United States Army under what is described as reverse lend-lease procedure. It is open to ranks of the Army, Navy, to merchant seamen, to members of the WACS, and personnel of the American Red Cross and the United States Embassy.

STAPHYLOCOCCUS OSTEO-MYELITIS-A CASE REPORT

F. L. Feierabend, M. D.

Kansas City, Missouri

Four days before entering the hospital this child complained of some pain in the left arm and shoulder. She was not acutely ill but the temperature was 101. She continued to complain about the left arm and shoulder and the temperature gradually rose to 102.6 the day before she entered the hospital. She became acutely ill, complained of intense pain of the left arm and shoulder and the temperature was 106.5. That day she had a severe chill.

On entering the hospital November 1, 1943, she presented a picture of a nine year old girl who was severely sick. She complained of severe pain in the proximal part of the left arm and the left shoulder, with a history of gradual onset, high temperature and chills.

Examination revealed marked swelling over the left deltoid area extending over the anterior aspect of the shoulder and down the arm. The area was hot. The veins were dilated. It was extremely tender to pressure. The patient complained severely at any attempt to move the shoulder. There was no fluctuation. There was a soft blowing murmur at the apex, which was not transmitted. Other physical findings were negative.

On hospital entrance the urine analysis was negative. The white count was 15750 with eighty-eight per cent polys and twenty-four per cent nonfilaments. Blood culture was started which later proved to be negative. Spinal fluid examination to include culture was all negative. Radiograph of the left humerus and shoulder revealed nothing.

She was given moderately heavy doses of sulfadiazine, sedatives and fluids. There was no improvement. The high temperature and chills continued. The swollen area over the left arm became increasingly tender and painful. I saw this patient on her fourth hospital day. There was fluctuation over the proximal portion of the left humerus and probably free pus in the soft tissues but it was not pointing.

Staphylococcus titre was ordered and the report given as greater than 1-512. This would indicate an enormous amount of immunity. This was discarded as being worthless and later found to be in error. Additional x-ray work was done on the third hospital day. This revealed some impairment of the calcium content of the neck and shaft of the humerus but no erosion of the cortex and no medulary softening.

Additional x-ray work done on subsequent days revealed the typical bony changes and left no doubt

as to the diagnosis of osteomyelitis of the left humerus. Blood sulfadiazine determination was made on the fourth day and it was found to be 25.48 mg. per cent. There was no improvement and surgical drainage was seriously considered. Since the sulfadiazine produced no improvement, although the blood concentration was 25.48, it was discontinued.

She was given 80,000 units of staphylococcus antitoxin with dramatic results. The temperature dropped to 99.8 and remained there all of the following day until midnight. The following day penicillin was started. It was given intravenously by a very slow drip. She was given 56,000 units daily for six days, then 28,000 units for seven days.

The response to this treatment was very impressive. The temperature returned to normal in four days and remained normal. The swelling and tenderness of the left arm disappeared completely in eight days. There was no surgery. X-rays made several weeks later revealed complete recovery and normal bone. No involucrum formed. To date there has been no recurrence,

DISCUSSION

I would like to say at the outset that one case proves nothing. I am merely giving this as a case report, following a request that I do so. I am anxiously awaiting the report from Dr. Chester Keefer on penicillin. A report of this case was made to him. I am of the opinion, however, that there is need for discussion of the diagnosis and treatment of osteomyelitis, especially regarding the use of staphlococcus antitoxin.

Although we had an early negative blood culture and no way to determine the type of infection, it was reasoned that this patient had a staphylococcus infection with blood stream invasion. It was also reasoned that she was toxic and was not developing any antitoxin. It is well known that in severe staphylococcus blood stream infections that the toxin does the damage. Most cases of osteomyelitis are caused by staphylococcus and where there are chills, it is safe to assume that there is a blood stream invasion.

Staphylococcus toxin has an influence on the blood forming organs and prevents the development of white blood cells. Therefore, if the white count is falling rather rapidly as in this case it is safe to assume that the patient is toxic and is not making antitoxin. This clinical observation in my opinion is very important. I would rather base my conclusion on this clinical fact than on any laboratory measurement of staphylococcus titer, because few laboratories seem to be able to make this determination accurately. Using this reasoning, it was decided to neutralize the staphylococcus toxin with staphylococcus antitoxin which we did with a dramatic response.

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The obvious improvement which immediately followed the use of staphylococcus antitoxin proves that the infection was staphylococcus, that the patient was toxic and was not making antitoxin. After the toxin was neutralized penicillin prevented any new growth of bacteria and the patient won her battle without surgery.

Since penicillin is a bacteriostatic we now have three modes of defense in staphylococcus osteomyelitis but we should not lose sight of the advantages

of staphylococcus antitoxin.

With staphylococcus antitoxin, we can neutralize the toxin and permit the patient to mobilize her forces of defense, by eliminating the effects of toxin on the blood forming organs and enhancing the patient's ability to develop new white blood cells. In this case the white count fell to 6,400 and three days following the use of antitoxin the white count was 25,800. Such response can not be ignored.

We now have a marvelous bacteriostotic in penicillin. We can neutralize staphylococcus toxin with staphylococcus antitoxin. The patient can build white blood cells if the toxin is neutralized and after all the white cells must destroy the bacteria.

CONCLUSION

I believe that many cases of staphylococcus osteomyelitis can be cured without surgery, if we use staphylococcus antitoxin and penicillin at an early date.

SULFATHIAZOLE IN GONORRHEA*

B. M. Marshall, M. D.

Topeka, Kansas

Owing to the discussions and different views among the clinic personnel on the results of giving sulfathiazole before or after meals, and the relation of blood concentration to results, a study of thirty-four cases of gonorrhea was made. Naturally not nearly all of those who had negative smears and cultures after the first week remain so; we have not attempted to ascertain the exact per cent who have relapsed, for our clinic is not adapted to this type of research because the patients are not confined and may reacquire the disease while under observation as proved by: (1) Pregnancies occurring during our three months' period of observation. (2) Contacts reported by the Army and other sources during the period of observation.

Of the cases recurring after two series (weeks) of sulfathiazole, we find in the female cervical stenosis to be the most frequent cause, urethral stenosis to be second. Removal of Skene's glands has not

been necessary because of massage over a No. 30 urethral sound. Bartholin's glands have been a cause of persistence of infection in less than one per cent of the cases. In the male the prostate was the most frequent cause, and urethral stricture or stenosis was found only rarely. Of course this was a young group.

Thirty-four cases of gonorrhea were taken at random. Probably most of these were early as they were young people maintaining active sexual contact. A dosage of one gram of sulfathiazole was given four times a day for one week. One-half of the patients were given the drug before meals and the remainder after meals. Blood sulfathiazole levels were taken not under forty-eight hours and not over seventy-two hours after the beginning of the treatment

- 1. Those taking the drug after meals show the most frequent variability of blood concentration.
- 2. The highest concentration was 4.5 mg. per 100 cc's.
 - 3. Variability from 1-4.5 mg. per 100 cc's.
- 4. Three positive cultures after one week of treatment (the rest were negative).
- 5. The average blood concentration of the whole group was 2.06 mg. per 100 cc's. Those taking the drug before meals showed:
- 1. Highest range of concentration (two cases too low to read to 4 mg. per 100 cc's.
- 2. Most uniformity (eight cases were between 2 mg. and 2.5 mg. per 100 cc's, while in the cases after meals, only three cases were within this bracket).
- 3. Two positive cultures were found taken after one week, and one positive slide.
- 4. The average blood concentration from the entire group was 1.7 mg. per 100 cc's.

The results bore no relation to the blood concentration (one negative where the blood concentration was too low to read, and one positive where the blood concentration was 2.2). No positives were found with blood concentrations over 2.2 in the group. Of course we have found positives with much higher concentrations in other studies.

The cultures were read by the oxidase method. No fermentations were run. No nausea was complained of in either group (this study was conducted in the hard-working group who had no idle time for whims). No renal complications were encountered. We suspect some of the very low concentrations may have resulted from failure of the patients to take their pills, as some have been proved prevaricators. It is interesting that no difference in final result could be found from those taking the medicine before or after their meals (three positives in each series). The highest concentrations, however, seem to favor the latter course, although the most uniform concentrations were gained from the before-meal administration.

^{*}Municipal V. D. Clinics, Topeka, City and Shawnee County.

President's Page

To the Members of the Kansas Medical Society:

Your new President's official duties to date have mostly been getting the committees arranged for the coming year. Most of the committees have been appointed and the chairmen have accepted the responsibilities. A few chairmen are yet to be heard from. As soon as they are heard from the committee list will be published in the Journal.

It has been our policy not to change the personnel of the more active committees any more than is necessary.

This is an election year. I think that all good doctors should take an active interest in politics and see that men are nominated and elected who can be depended upon to faithfully discharge their duties as officers of our states and nation. I think it is particularly important that we see to it that good men are elected to the legislature.

It has come to my attention that in several counties men that are distinctly unfriendly to medicine have filed and are in the primary race for places in our legislature. If the doctors take an interest in the elections and do their civic duties, there is no reason why those unfriendly to us should be representing us in the legislature.

Greetings to the new Secretary: Mr. Oliver Ebel has been elected as our new executive secretary of the Kansas Medical Society. He is known to most of our members as the very efficient executive secretary of the Sedgwick Medical Society. He was with us at the state meeting and took care of the commercial exhibits besides helping Mrs. Foster with many of the other details of our meeting.

We are glad to have you with us Mr. Ebel and know that you will fill this office with honor to our Society and credit to yourself. We hope that in the years to come the Kansas Medical Society will get to know you better and love you more each year. We are glad to have you join us and I wish to extend to you a hearty welcome in behalf of the Kansas Medical Society.

Sincerely yours,

President, The Kansas Medical Society

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EDITORIALS

EBEL NEW EXECUTIVE SECRETARY

The membership and the employees of the central office are most happy to welcome Mr. Oliver Ebel of Wichita, as the new executive secretary of the Kansas Medical Society, on July 1, 1944.

Born at McPherson, Kansas, on July 3, 1909, his parents, Prof. and Mrs. B. E. Ebel, now of Redlands, California, moved to Boston, Massachusetts, where he attended grammer school. He graduated from the University of Redlands in California in 1931 and attended the University of Kansas 1931-1933 where he completed post graduate work. He ac-

cepted a position with the county welfare board in Wichita and was later chief probation officer in the Sedgwick county juvenile court. In March, 1942, he was employed by the Sedgwick County Medical Society as its executive secretary to succeed Mr. John (Jack) Austin who had resigned to enter military service and is now a captain and public relations officers at Fort Bliss, Texas

Mr. Ebel succeeds Mr. Robert Brooks and the former executive secretary Mr. Clarence Munns who is at the present time a major in the United States Army Air Corps in England.

The Society is greatly indebted to the Sedgwick County Medical Society for relinquishing Mr. Ebel to the state organization.

The new executive secretary has been in great demand as a public speaker on lay medical subjects and has appeared before numerous groups throughout the state. Under his capable management the Sedgwick County Medical Bulletin has become one of the outstanding county medical publications of the country and its material is widely read and copied. He is an able director, organizer, promoter, and writer on subjects related to medicine and his leadership in the central office is greatly needed by the profession under war, post-war, post-graduate, legislative, and the formative periods of the new physician's service program. He has demonstrated in an efficient manner his capabilities and his knowl-

edge of the problems facing the state and national profession and the Society is indeed fortunate in securing his services at this time.

HOW WELL DO YOU READ YOUR JOURNAL?

That is a question that is hard to determine. Our service men in far places say that they read every word and then pass it on to others who do not receive a medical publication. One time a columnist was heard to remark: "You never know who reads your stuff 'till you make a mistake and then—do they ever let you know about it."

The Journal is now facing the problem of loss of advertisers, because our members will not reply by mailing in attached coupons. The only method an advertiser has to determine the pulling power (or

sales value) of a publication is the number of coupons returned.

Several new advertising companies have appeared recently in your Journal, we hope you have noticed them and more will appear from time to time. Please remember that all Journal advertising is approved by the editorial board and the products examined and approved by the Council on Pharmacy and Chemistry of the American Medical Association for your protection.

We believe that our Journal is read by the majority of our members but to prove this to our advertisers, who use coupons in their ads, it is necessary that Kansas members fill in and return these coupons from time to time. No other coupon will do, but that published in our Journal, for

all coupons are keyed to assure the advertiser from what Journal they have ben torn. If you do not wish to destroy your Journal we will try, in so far as possible, to furnish some of you with a second Journal, if this is necessary. But if you believe in your Journal and want it to continue to receive good national advertising please remember to mail in your coupons.



OLIVER EBEL

Dr. George Karsner of Glasgow writes:—"In conversation the other day with a non-German refugee, the casual remark was dropped that eah member of every German tank crew possessed the same blood group and this was also true of the submarine crews. The advantages of such a provision are obvious."—In a letter from the British Medical Journal.

MEN IN SERVICE

A SURGEON'S PRAYER IN WARTIME

"God of Battle, grant that the wounded may swiftly arrive at their hospital haven, so that the safeguards of modern surgery may surround them, to the end that their pain is assauged and their broken bodies are mended.

"Grant me as a surgeon, gentle skill and intelligent foresight to bar the path to such sordid enemies as shock,

hemorrhage and infection.

"Give me plentifully the blood of their non-combatant fellowman, so that their vital fluid may be replaced and thus make all the donor people realize that they, too, have given their life's blood in a noble cause.

"Give me the instruments of my calling so that my work may be swift and accurate; but provide me with resourceful ingenuity so that I may do without bounteous supplies.

"Strengthen my hand, endow me with valiant energy to go through day and night; and keep my heart and brain attuned to duty and great opportunity.

"Let me never forget that a life or a limb is in my

keeping and do not let my judgment falter.

"Enable me to give renewed courage and hope to the

living and comfort to the dying.

"Let me never forget that in the battles to be won, I too, must play my part, to the glory of a great calling and as a follower of the Great Physician. Amen."—John J. Moorhead, Colonel M. C., Trippler General Hospital, Honolulu, T. H., Christmas Night, 1941. From—Journal of the Oklahoma State Medical Association.

Major M. E. Pusitz, of Topeka has been transferred from Hammond General Hospital to Fort Lewis and then to Camp Haan where he is Chief of Orthopedic section and Chief of the Physiotherapy section. Major Pusitz is the author of a recent article entitled "Physical Therapy in Compression Fractures of the Spine" in the Physiotherapy Review which was abstracted in the May issue of Modern Medicine.

The Ohio State Medical Journal contains the following item: "Here's what Don Caswell, United Press correspondent with American Forces in New Guinea, has to say about the medical services available to the soldiers on that battlefront: 'In the swampy, feverish jungles of New Guinea . . . Army surgeons are performing daily miracles unheard of in the World War I. I have just visited an American Field Hospital in the New Guinea bush country, where more than 200 wounded soldiers have been treated since the Buna offensive started November 19. In the last war, surgeons would have expected at least a score of amputations from such an assortment of damaged bodies. But up to date (December 8) not a single one has been performed here.'"

Dr. Lattimore has the following letter from Capt. Robert H. Moore located for a time in Lansing, who has an APO out of San Francisco: "Your very welcome and newsy letter came today. It was quite a booster to hear from you and news of the Society. I am very interested in your P-G plan—not especially in a financial way, however, that may come later. I want three to six months in surgery. The only place I know of is the Polyclinic in New York. Would appreciate any suggestions you may have. We are

very busy as you may expect from the news of late. In fact I'm sure we are going to be doing a lot more. Have been in the field with this outfit now nearly twenty months. Sorry to hear Clarence will not be with us again but we all feel he did his job and is deserving a future of his choice, may he be happy. The insurance angle of medicine seems to be more prominent every day. May your efforts not be in vain. Any dope you may have in regard to the P. G. will be most welcome. Remember me to Dr. Loveland. See you in '45."

Lt. Demearle E. Eckart, of Tescott and Linn, Kansas, was recently awarded the Navy and Marine Corps Medal "for heroic conduct while attached to the U. S. S. Henley on occasion of torpedoing and sinking of that vessel by enemy Japanese forces in the Southwest Pacific area, October 3, 1943. Although he himself was covered with fuel oil, Lieutenant Eckart labored tirelessly aboard heavily overloaded life rafts in order to render prompt first aid to survivors. Eventually picked up after nearly eight hours in the water, he continued his efforts in behalf of the wounded, rendering invaluable assistance to the medical officers of the rescue ship even though he was seriously ill as a result of swallowing quantities of oil. His courageous spirit of self sacrifice and steadfast devotion to duty were in keeping with the highest tradition of the United States Naval Service."

Lieutenant Eckart graduated from the University of Kansas School of Medicine in 1940 and entered the service on July 18, 1942.

Comdr. John M. Porter, of Concordia, recently returned from two years of service with the Navy in the Pacific addressed an audience in Fraser hall at the University of Kansas recently.

Comdr. C. H. Warfield of Wichita in a v-mail to the central office has the following to say: "Received the March issue of the state Journal rather late but very welcome. I was detached from Brooklyn and assigned to the above mobile hospital two weeks ago. All I can tell you is that I am somewhere in New Caledonia a really beautiful spot for a winter vacation. However, I would much rather have my wife and children along. Met Ward of Arkansas City (Lt. Cmdr. D. A. Ward) who is on his way up north. This is really down under and on the other side, but one of the finest hospitals in the Pacific. It is winter here but Kansas wheat would not freeze at any time."

Mrs. A. E. Cooper of Logan writes: "Would it be possible to have Dr. Cooper's medical Journal sent to him overseas as I am sure he'd enjoy the reading of various articles as well as the military column and editorials. I have been sending clippings and it is so difficult to forward the magazine to him as men overseas do not receive them as they should unless sent direct from the publishing office." Lt. A. E. Cooper is stationed somewhere in England.

Capt. R. E. Baldridge of Kingman and Major F. W. Matassarin of Wichita have both informed the Journal that they have been transferred to the Kennedy General Hospital at Memphis, Tennessee.

Major Garth S. Ortman of Kansas City, formerly stationed at Camp Robinson and Glendale, California, has been transferred and now has an APO out of San Francisco, California.

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Lt. George L. Norris of Olathe has been transferred from Balboa, California, and now has an APO address out of New York.

Lt. Comdr. L. N. Speer of Kansas City is now stationed at the Marine Corps Air Station at Cherry Point, North Carolina.

Capt. D. H. Wood has been transferred from Battle Creek, Michigan, to Pittsburg, Kansas.

Major J. R. Nevitt of Moran has an APO address out of New York.

Major W. C. Schwartz of Manhattan has been transferred from Dallas, Texas, and has an APO address out of New York.

Capt. C. V. Minnick of Junction City has a recent APO address out of San Francisco, California.

Major R. E. Speirs of Spearville has been transferred from Fort Leonard Wood, Missouri, to Toledo, Ohio.

Capt. Max E. Kaiser of Ottawa has been transferred from Omaha, Nebraska, to Camp Anza, Arlington, California.

Capt. M. E. Christman of Pratt has been transferred from Colorado to Venice Army Air Field, Florida.

Dr. Leslie E. Knapp of Wichita, a lieutenant colonel, is stationed at the 67th Station Hospital in Miami, Florida.

Lt. Philip Hostetter of Wichita has an APO out of San Francisco, California.

From England we have the following from Capt. John F. Bowser of Kansas City: "The Journal arrived late because of the old address on your mailing list. Please change it. I appreciate receiving the Journal while overseas and I know that it is appreciated by several members of this command."

Major Kenneth J. Gleason of Newton has been transferred from Camp Rucker, Alabama, to an APO out of New York.

Capt. Joseph Manley of Kansas City has an APO out of New York.

"Please send the Journal to the new address." Major Alfred H. Hinshaw of Kansas City has an APO address out of New York. Major Hinshaw has recently been stationed at Atlantic City, New Jersey.

Capt. Geo. F. Gsell of Wichita, stationed at Lowery Field, Denver, Colorado writes to advise us that he has now received his majority. Congratulations Major Gsell, we had a fine visit with your father at the state meeting.

Lt. R. M. Wyatt of Hiawatha has been transferred from Enid, Oklahoma, to Randolph Field, Texas.

Lt. John Aldis of Osawatomie and Emporia has been transferred from Atlantic City, New Jersey to an APO address out of New York. Lt. Aldis had been stationed at Langley Field, Virginia.

Lt. Francis A. Thorpe of Pratt has been transferred from Atlantic City, New Jersey, to an APO address out of New York.

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Lt. J. T. Marr of Sterling has been transferred from Moore General Hospital in Swannanoa, North Carolina, to Camp Gordon Johnson, Florida.

Major M. R. Blacker of Wichita has been transferred from March Field, California, to the Army Air Base in Portland, Oregon.

From Fairbanks, Alaska, Major Leon B. Thomas, formerly of Russell, writes: "Please be advised of my change in address from Tacoma, Washington, to an APO out of Minneapolis, Minnesota. I would appreciate your sending my Journal to this address."

Capt. Corbin E. Robinson of Hoisington and Capt. Leon W. Zimmerman of Liberal were listed as graduating on March 15 in the aviation medical examiners course, according to publication in the May 13 Journal of the American Medical Association.

Dr. Edward Haslam, son of Dr. and Mrs. T. P. Haslam of Council Grove, has recently been promoted to lieutenant commander in the Navy. Lt. Comdr. Haslem is attached to a mobile hospital unit.

Capt. Frank K. Bosse of Atchison, with an Air Corps unit in New Guinea, recently spent a furlough in Australia. On returning to New Guinea the first person he met was Capt. Wayne O. Wallace, also of Atchison. Capt. Spencer Fast of Atchison, according to the Atchison Globe, was stationed not far away.

Capt. Lucien A. Watkins of Leavenworth is now stationed at Lowry Field, Colorado.

Capt. L. A. Procter of Parsons has been transferred to Fort Snelling, Minnesota. He was formerly stationed at Springfield, Missouri.

Capt. Martin J. Rucker of Sabetha recently attended a post-graduate school in anesthetics conducted by the U.S. Army in England. Captain Rucker is surgeon of the eye, ear, nose and throat department in an Army evacuation hospital in England. Instructors in the school were medical experts who had experienced the recent campaigns of the European theater, and the work covered field hospital treatment.

The next few items about Wichita doctors have been abstracted from the Sedgwick County Medical Society Bulletin:

Lt. Austin J. Adams at a Fleet postoffice out of San Francisco writes: "Have been getting in some new medical equipment, our pride and joy is the new operating van (large) with operating table. Has six dual-tired wheels, all large lugged and large size. Has fifty gallon water tank with running water, its own portable 110 generator which we borrowed from the dental officer. The front end has cabinets, shelves and sink—and looks like a model kitchen. The bed, eight feet, has a table and two Castle-lights. It is all in light green with dark green trim. Surely is marvelous how the Seabees can produce all the materials

from such a place as this—lights, hinges, plugs, fans, etc. We are now equipped to do most everything, so are more than an aid station."

Capt. H. O. Anderson says: "I may try to bring you up to date since our last move. We have at last almost an ideal set-up for a hospital, considering what we had before. We are still in tents and huts, but we have hot and cold running water, cement floors, sinks, and a shower in surgery, possibly the only one in North Africa, and a fair amount of surgery and traumatic work. We are not so rushed as we were a year ago, and we possibly aren't quite as ambitious."

Major Wayne C. Barrett writes: "Just a note to tell you that all is well with both Capt. J. B. Fisher and myself. As you can see, we have changed APO's again and are out in our tents once more. We have found them warmer than the English homes we were billetted in for a time (they were heated with a tiny fireplace only.) We will soon have been overseas two years, which is quite a spell (the first two years are the hardest, they say) and as you know went through the African and Sicilian deals. We are looking forward to bigger and better shows, and eventually home."

Lt. L. A. Donnell says: "Rather than have me stagnate in one spot, good old Navy transferred me from Base Hospital last month, and I am now medical officer for a Seabee outfit on still another island. It has been over twenty-five months now since I've walked down the streets of Wichita, but the time has passed so quickly that it hardly seems that long. From what I hear and read the place must be past recognition. Also it has been more than a year since I've seen a train, or a white woman, or smelled a hamburger cooking. So many of the things that seemed so commonplace and unimportant are the ones that I miss the most. In this section of the world summer is almost over, which doesn't mean a thing. Since it rains all day, and the thermometer stays right around ninety, come summer, spring or fall, it doesn't make a bit of difference. Upon receipt of your letter, I immediately interviewed several people of local importance and asked for a statement for publication. Obligingly, a Fijian Chief, a Solomon Islander, a Seabee lieutenant, a Navy commander, a Marine corporal, and an Army major, said, 'I wanna go home.' And those, gentlemen, are my sentiments.'

Major R. L. Drake sends greetings: "The past several days were spent in knee-deep mud of New Guinea in an area which was taboo by even the natives. Really, New Guinea can produce rain and mud which you finally give in to and decide you will never be clean again. Finally we moved our tents to this area which is a coconut grove all laid out in rows. There are plenty of reptiles, rodents two feet in length, lizards, and other play-things in the jungles. The natives are the fuzzy-headed type but at present we do not see many. Some of them are used as laborers. They have no use for the Japanese at all but are friendly to us and the Australians. It is permitted to say that we are in a busy advance base somewhere in New Guinea. We have rains daily and use a blanket for cover each night. The temperature varies between seventy to ninety-two the year around. To all the boys in the Service I will use the Australian greeting, Are you happy? Good luck to you."

Capt. James B. Fisher is now a Diplomate of the American Board of Internal Medicine, with his written examination taken in a tent in North Africa and the Oral passed at Oxford. Captain Fisher recently addressed a medical society in England on the "Miller-Abbot Tube."

Capt. Clyde W. Miller of Wichita has this to say: "I have arrived on the lower half of the globe, somewhere in New Guinea, and am enjoying the new scenery and unusual experiences. The weather is similar to Southern California, however, the excess elements would make Kansas the best agricultural state in the union, but very annoying to the foreigner."

From Comdr. H. F. O'Donnell: "Since I wrote you (the Sedgwick County Bulletin), our ship has been very active, and has traveled so many thousands of miles that I have lost count. Now that it is ancient history and has been published in the newspapers, I am permitted to say that one of our jobs was the care of a large number of those wounded at Tarawa. One of the things that I have learned from our experience is what a remarkable fighting force we have in the United States Marines. With their marvelous esprit de corps plus their physical toughness and excellent training and equipment, they are exceptionally bad news for the Japs." (Dr. O'Donnell is chief surgeon aboard a hospital ship, according to a recent newspaper story.)

Major H. W. Palmer writes: "For the past four months I have had a nice assignment on the mainland of Australia at a Rest Camp area. I was in charge of the dispensary at that station and really got to practice some medicine for a change, what with dengue fever and malaria (recurrent and contracted in forward areas). Enlisted men were brought to our station for a ten day period and were again given beds to sleep in, horses to ride, white table cloths and excellent food. The place speaks well for itself when the G.I's. would gain from seven to ten pounds weight in their leave of ten days. The ARC provided all entertainment, including a dance six nights a week with a show on Sunday night."

Comdr. C. K. Wier writes the Bulletin: "I'm enclosing a few notes from my experiences at sea in which you may be interested. Having many freshly wounded men aboard is an experience not to be forgotten but I hope not often repeated. Plasma, morphine, untiring efforts of doctors and corpsmen saved many who otherwise would have been lost. One's first presence at a sea burial causes profound thoughts, equaled only by removing bodies from a battered raft. At one hospital I saw a descendant of Fletcher Christian (Mutiny on the Bounty) being treated for a fractured zygoma—having igonminously fallen from a coconut palm. ... Waiting between invasions, fishing and swimming in the Mediterranean, this close to war (though it seems far away) and Arab shepherds, watching hillside flocks, make war seem almost impossible. When it comes there is chain cigarette smoking during the bombings, and we learn to pray. Wounded men begin to return from the beachhead, a few of the enemy among them. There are no complaints, each casualty stoically waiting his turn-you are proud of every one of them, glad to belong to such a tribe. The enemy casualties are non-commital as their bombers raid us, apprehensive when they hear our planes sweep over. Days later, out of the 'hot area,' 'Deep in the Heart of Texas' comes over the ship's radio and all casualties, who can, roll it out. ... Many hours spent with the men of the British Eighth Army, those original Desert Rats who did the pioneer fighting in Africa, under Wavell. Lean, hard, uncomplaining men, and some of them away from home for five years. Their swinging gait while marching, which they can keep up for hours on end, would thrill a pacifist. ... Scotland in the mist. Rosy cheeked children, freshly scrubbed men and women. Pubs. Fish and chips. And then we were up-anchoring and sailing JUNE, 1944 207

EAMP ANATOMICAL SUPPORTS



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GGETHER with treatment for any existing I infection of the urinary tract, Camp Supports have proven valuable adjuncts in the relief of symptoms in many cases.

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- 4. Camp Supports stay down on the body by reason of the foundation laid about the pelvis.
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Camp fitters ask patients to return to their physicians for approval of the fitting.

down the Clyde for home. And my family, the doctor to relieve me, my orders for shore duty all await me at the same port. While the duty as chief of orthopedic surgery is in as fine a set-up as I have ever hoped to find. The men in the department are excellent, well trained. These men have mostly been overseas, they know what it is all about, they are grateful for their respit here, yet not one would utter a comment if sent back tomorrow."

Capt. C. L. Woodhouse notes: "My trip over was most enjoyable, with a fine bunch of officers, good quarters, and no excitement. This island is quite large and was at one time a French Penal Colony. Our camp is in a beautiful location, between the mountains and the ocean and a very long distance from the only city. The climate is ideal, and from what I hear of the other islands, this is the nicest one of all. We have a deep, clear mountain stream very close and swim every day. . . . This is a field outfit, and we stay only a few weeks in one area. My dispensary, which I share with the dentist, is a pyramidal tent with a wooden floor and running water. We are well equipped for this type of work. There is very little sickness, but quite a lot of fungus infections, and they require more treatment than the ones usually seen at home."

Dr. Paul B. Young, now a captain, is with a fighter squadron located half way between Atlantic City and Philadelphia.

Dr. Lattimore had the following from Capt. Dave Gray of Topeka: "This English spring time is beautiful and we're bivouacked on the grounds of a big estate—living in tents but I have a small dispensary building. Incidentally, I don't know whether any of the other fellows are with infantry outfits—the Air Corps seems more enticing—but I want to put in my two bits worth for the infantry man. He's not very pretty to look at but I'll go with him any time. I noticed the remark concerning my APO in your letter said '328th Infantry'—it happens to be the 329th, a small item but we're right proud of our bunch. Give my regards to any of the fellows you see and keep up the good work. Will be back one of these days. Would like to see some of the fellows over here but I don't believe any are very close to me."

From Capt. Robert Sohlberg, Jr., of McPherson we have the following letter: "Please change my Journal as listed below. (Camp Mystic, Hunt, Texas.) I have been assigned at this station as post surgeon since November. This is a convalescent camp for patients from various station hospitals in the Central Flying Training Command, as a result of which we have received patients from as far north as Liberal and Winfield. Our purpose is to recondition patients following hospitalization and return them to duty as soon as possible. We have facilities for all types of sport including horseback and bicycle riding, swimming and canoeing. This post was established in conjunction with the convalescent training program which the Army Air Forces inaugurated and which seems destined for rapid expansion. At present I am sweating out the 'duration and six months' (I hope it won't be too much longer than that) awaiting that happy day when I can return to the private practice of medicine in Kansas. With best regards to all the boys.

Mrs. John N. Blank of Buhler writes us the following: "Will you send the Journal to Major Blank direct—Dr. Buhler was first sent to the Island of Oahu in the Hawaiian group, and from there to New Guinea and from what

I can gather he arrived there in February. He likes his present set-up very much, as far as the Army is concerned. He supervises all the other doctors in the artillery, censors mail, works at the dispensary. Of course, he can tell me very little since overseas. As he writes 'About all you know I do, is go fishing, as censorship is so very rigid for ground forces.' He is having good luck fishing (the last and largest caught was said to be a seventy-two pounder dressed according to the General's guess, who was also on the trip). In three hours, seven of them caught enough fish to feed half a battalion. So during their spare time they seem to be having fun."

Lt. C. D. Blake, of Hays, son of Dr. and Mrs. Clyde Blake has a fleet post office address out of New York.

Lt. Comdr. Henry H. Crank of Topeka is at present located at Farragut, Idaho, where he is assigned as a neuro-psychiatrist at the Navy Hospital.

Dr. C. Van Pelt of Riley and Junction City has been commissioned a lieutenant in the U. S. Navy. Lieutenant Van Pelt is the son of Dr. C. L. Van Pelt of Paola.

Major Edwin T. Wulff of Atchison has been transferred to Colorado.

Dr. M. W. Hall of Wichita, originally with the Thirty-Fifth Division, has been promoted to lieutenant colonel, according to war department news.

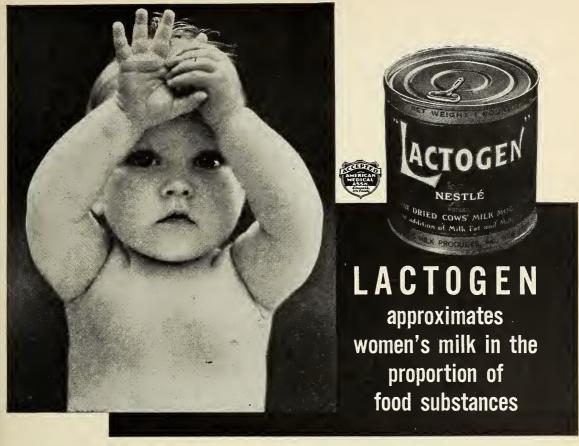
The Council Grove Republican printed the following news item: "Dr. Leland P. Randles (of Fort Scott) and his brother Howard Randles had a happy reunion in England last month. Howard went over seas two years ago and Dr. Leland arrived in England the first of the year so they soon arranged a meeting. On January 12 Leland was advanced to the rank of captain and the first of February Howard also received his advancement to captain. They are the sons of Dr. and Mrs. Herbert Randles of Fort Scott, formerly of White City."

Lt. Comdr. A. C. Irby, of Fort Scott, returned from the Aleutians after a year there with the Seabees, had the following remarks to make: "Although the strong winds and continuous ice and snow are a constant menace, the cold never differs much from the Kansas brand, with the lowest this winter nine above zero. Rheumatism was the principal ailment, caused presumably by climatical conditions."

Recent War Department promotions included: William Claire Menninger of Topeka promoted to colonel; and Edward Raymond Christian of Rozell to captain.

Ross T. McIntyre, Surgeon General of the United States Navy, says, "If an American service man is wounded today on any of the battlefields of the world, the chances are forty-nine to one that he will recover, thanks to the miracles being performed by American Army and Navy doctors and laboratory scientists.

"And, if an American Navy man contracts some disease, whether on one or another of the seven seas or any continent, the chances are more than 1,500 to one that he will come out fighting." Yet we have folk in Washington who would upset all that has been done by the grandest of all the professions—Journal of the Indiana State Medical Association.



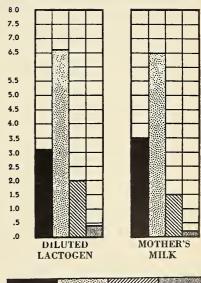
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NEWS NOTES

NARCOTIC PERMITS

Federal narcotic permits under the Harrison Narcotic Act must be renewed by July 1. Application for the renewal of your narcotic permit is made through the office of the Collector of Internal Revenue at Wichita, and the attention of the membership is made to renewal of permits in order to avoid payment of penalty. According to an editorial in the June 3 issue of the American Medical Association Journal a physician in the armed forces need not reregister. If he receives an application form for reregistration it should be returned to the office of the Collector of Internal Revenue together with a statement showing that he is in service and requesting that registration number previously assigned to him be reserved.

BOARD OF REGISTRATION AND EXAMINA-TION MEETING

Dr. C. E. Joss of Topeka was elected president of the Kansas State Board of Medical Registration and Examination at its meeting held in Topeka on June 8. Dr. Joss succeeds Dr. M. C. Ruble of Parsons the former president.

At the business meeting Mr. Clarence Beck of Emporia was reappointed as the board's attorney. Mr. Beck had resigned as the attorney sometime ago to accept another position and at the entrance of Mr. Lloyd Ericsson of Emporia the present attorney into military service the attorneyship was again left vacant and Mr. Beck was reappointed to the position.

Governor Andrew Schoeppel reappointed Mr. M. C. Ruble of Parsons and Mr. H. E. Haskins of Kingman as members of the board on June 8. Other board members are: Dr. J. F. Hassig of Kansas City, the secretary; Dr. W. C. Jones of Olathe; Dr. J. D. Colt of Manhattan; Dr. C. E. Joss of Topeka, and Dr. George R. Dean of McPherson.

A.M.A. OPENS WASHINGTON OFFICE

On April 3 the new Washington office of the American Medical Association, located at 1835 I. Street Northwest, suite 900 in the Columbian Medical Building was opened by decision of the Board of Trustees at its February meeting. Whether or not to open a Washington office has long been a controversial issue but it is believed that the Washington office can be of much assistance in medical matters pending in future congresisonal halls.

Although the control of the office will still be in the hands of the office of the council and secretary of the American Medical Association in Chicago, Dr. Joseph S. Lawrence of Albany, New York, will head the new office which will distribute medical information and have closer contact with legislative activities in the capital city.

VENEREAL DISEASE PROBLEM IN SEVENTH SERVICE COMMAND AREA

The following communication was received from Col. H. C. Moore, surgeon of the Army Service Force, Head-quarters of the Seventh Service Command of Omaha, Nebraska, and it is hoped that the information therein will be read in full by our members:

"We of the Seventh Service Command appear to have reached a stalemate in our fight against the venereal disases. The venereal rates for the Army in this area showed steady downward trend until the middle of 1943. Since that time we have at best only held our own. Rates for the fiirst two months of 1944 are actually 50 per cent higher than those of the corresponding months of 1943. It appears, then, that we are faced with the probability of a reversal of the favorable trend of recent years.

"I am addressing you as representative of the medical profession of the state of Kansas, to enlist even greater aid from that important group in our effort to reduce the toll of venereal disease in our ranks. Lest any physician fail to recognize the opportunities for contribution of this end, the following means are submitted for his consideration.

1. Refuse to treat officers or enlisted personnel of the Army for venereal disease without the specific approval in each case of the soldier's commanding officer. Army regulations require the soldier to report the existence of symptoms of venereal disease. Failure to do so subjects him to the possibility of disciplinary action. The physician who treats the soldier is thus entering into collusion to circumvent Army regulations. Of considerably more practical significance is the fact that the individual undergoing therapy with sulfonamides or arsenicals unknown to his unit officers may be placed in a position to endanger his life and that of his comrades.

2. The physician should support (and lead) community sentiments against prostitution, open or clandestine, with all the weight of his position as a community leader. We would like to ask him to go further—in his public and private contacts to foster the development of those influences in home, school, church, and elsewhere which will strengthen the moral convictions of our youth and confirm them in continent behavior.

3. Support the extension of the community health services; assume leadership in the effort to establish and maintain an adequate preventive medical program for the community. The physician (as guardian of health) bears a heavy responsibility for leadership and direction in these matters.

4. Recoginze a grave responsibility in connection with the treatment of civilians with venereal disease; insist upon continuity of treatment to cure, using the services of the health officer, when necessary, to insure this. Share with the health officer a sense of responsibility for contact finding. If a busy practice prevents his active participation in this essential phase of the control effort, the physician may call for the assistance of the health department. Of particular concern to us, of course, are the contacts with military personnel, officer and enlisted, that are frequently obtainable by careful questioning.

5. Sad experience has shown us that present methods in the diagnosis and treatment of gonorrhea, especially in the female, leave much to be desired. Findings of positive bacteriologic evidence of gonorrhea in the absence of symptoms have been shown to extend in an appreciable percentage of cases beyond the third month of observation. A disturbingly large number of individuals repeatedly named as the probable source of a gonorrheal infection show no clinical or bacteriological evidence of the disease. Reports occur with alarming frequency which indicate that women under treatment for gonorrhea have continued to infect soldiers. In the face of these convincing demonstrations of the inadequacies of diagnostic, treatment and control measures what is our recourse? Several safeguards suggest themselves:

a. A more cautious attitude on the part of the physician toward the individual under suspicion of gonorrheal in-

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that the best interests of patients require that they receive advice on matters pertaining to health from qualified physicians only, we confine all advertising on our gynecological products to physicians and the druggists who serve them.

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fection—in particular, a greater reluctance to accept the negative laboratory report or negative clinical evidence is indicated.

b. Improvements in the thoroughness of physical examination including:

(1) greater use of laboratory services (dark-field) in the detection of the Treponema pallidum.

(2) better technic in obtaining specimens for Gram stain or culture in gonorrhea suspects and the recognition of the necessity for repeated examinations.

(3) greater use of the consultant and laboratory services of the health department in doubtful cases.

6. Observations on the inadequacy of present methods have implications which the cautious physician will immediately recognize. In particular I should point out:

a. the medical absurdity inherent in the certificate of freedom from venereal disease and the dangers involved in the common practice of giving patients (negative) laboratory reports.

b. the responsibility which the physician must assume for attempting to control the sexual activities of his patient until the probability of continuing infectiousness has been reduced to a minimum. This will necessitate carefully explaining to each patient the nature of his disease and the responsibility of his family and to society which the diagnosis entails. It may necessitate blunt warning to the careless; the invocation of legal measures against the recalcitrant.

c. the need for larger participation of the private practitioner in the effort to "sell" modern venereal disease prophylaxis to the public and especially to his patients."

"Dr. Pelouze, Assistant Professor of Urology at the University of Pennsylvania, has recently developed many of these points in an arresting article in the March issue of Venereal Disease Information. A consideration of his observations and deductions is recommended to all of our profession who would serve intelligently in this vital phase of the war effort."

NEBRASKA MEDICAL PRACTICE ACT

The following information was furnished by Dr. C. E. Joss of Topeka, president of the Kansas State Board of Registration and Examination:

The Nebraska Legislature in 1943 amended the Medical Practice Act, and the following sections are of general interest, particularly in the present action of the various cults in their attempts at recognition as medical practitioners:

"Sec. 71-206. Every person, licensed under this act to practice a profession, shall keep such license displayed in the office or place in which he or she practices and place and keep placed, in a conspicuous place at each entrance thereto, a sign, in intelligible lettering not less than one inch in height, containing the name of such person and immediately followed by the recognized abbreviation indicating the professional degree, if any, held by such person. In addition to the foregoing, those persons licensed to practice osteopathy, chiropractic, chiropody or optometry shall cause to be placed upon such signs, a lettering of equal height, the word, 'Osteopath,' 'Chiropractor,' 'Chiropodist' or 'Optometrist,' as the case may be; Provided, further, the same wording shall be used in all signs, announcements, stationery and advertisement of such licensees."

Whenever a license is suspended by any licensing body, the case may be heard by right of appeal to the district court calendar over all other cases except compensation and criminal cases. "Sec. 71-1403 (B). Any person now licensed to practice osteopathy in the State of Nebraska may, if application is made prior to July 1, 1948, and upon payment of the prescribed fee, take the first regular examination given after the application is made before the Board of Examiners in Medicine and Surgery. If such person is successful in passing such examination, he or she shall receive a license to practice medicine and surgery in the State of Nebraska; Provided, however, that any doctor of osteopathy, now licensed and practicing in the State of Nebraska and who is able to show satisfactory evidence of having taken and successfully passed the regular examination in medicine and surgery, shall be issued a license hereunder upon payment of the prescribed fee."

It is interesting to note that out of twenty-five osteopaths who took the examination, six passed. This gives them the right to practice medicine and surgery, but not the right to use the title of M.D.

The Board reserves to itself the right to accredit medical colleges, fixing the standards for such medical schools; the application is to be made by the school, it being necessary that such be accepted by the State Board before any graduates of such schools may obtain a license. In Part 11 of this section an osteopathic college may be also accredited if it fulfills the minimum requirements.

PURPLE HEART TO WICHITA NURSE

Sec. Lt. Helen A. McCullough of Wichita, a nurse, was awarded the Purple Heart for wounds received on March 29, 1944, in Italy. The War Department recently listed eight second lieutenants of the Army Nurse Corps for the citation for wounds received as a result of enemy action in Italy.

NAVY DEPARTMENT MAKES REQUEST

Comdr. Robert C. Ransdell of the Division of Publications of the Bureau of Medicine and Surgery Navy Department at Washington 25, D. C., has recently written to the Journal requesting that we publish the following information:

"The National Naval Medical Center of Bethesda, Maryland, is endeavoring to collect for its archives a complete set of commissions issued to Naval medical officers, and signed by past Presidents of the United States. There is a small nidus now at the Center and it is hoped to be able to build this up to completion. Through the Navy Department Library and the National Archives a few more have been located. I am wondering whether you care to insert a small item in your Journal to this effect, with the idea that various libraries or individuals may have in their possession such old commissions and would be willing to turn them over to the Center. If such are found and the owners are so generous, there could be no more fitting enshrinement of them than their use for this purpose. Any assistance that you and the Journal can extend will be greatly appreciated by the Surgeon General."

PRESCRIPTION WRITING

"How to write a prescription" long has been a controversial point in some circles, and the Medical College of Virginia has launched a program that may, in time, be the answer, according to a recent editorial in the Journal of Indiana State Medical Association. A communication from the Department of Pharmacology of this college states, "One of the most difficult problems in the teaching of



In patients with marked apathy and associated low muscle tone and low resistance, dramatic response may often be effected by adrenal cortex therapy when these symptoms are due to adrenal cortical insufficiency.

Adrenal Cortex Extract (Upjohn) used as replacement therapy in these cases often restores alertness and a healthy outlook. It relieves asthenia, strikingly increases resistance to infection, improves capacity for work, and strengthens muscle tone. Available for subcutaneous, intramuscular, and intravenous therapy.

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medical students is that of prescription writing." It goes on to say that a prescription is a message from a physician to a pharmacist, and that an understanding between the two is vitally necessary. In the Virginia school the plan of having this subject specifically taught recently has been adopted and a course of eight lectures is given each term. Further, in this course the Federal narcotic laws are carefully explained. While the program is rather new, it is declared to be working out most satisfactorily. There is no doubt that this subject has not been very well taught in most medical schools.

ADDITIONAL POINTS IN SPECIAL DIETS

The following communication has been received from Mr. R. S. Fanestil, District Food Rationing Officer in regard to the necessity for additional points in special diets, which we believe will clarify this question for our readers. The Office of the District Director for Kansas is located in the York Rite Building in Wichita.

There has been great confusion concerning requests for additional points for special diets. In order to clarify this situation the following specifications must be included with your prescriptions to this Board:

- 1. State nature of illness.
- 2. State whether special diet is of a temporary or permanent nature.
 - 3. Specify date when patient was placed on diet.
- 4. State total amount of rationed food needed per week, specifying each of these foods in ounces of meat, fats, sugar, and processed foods.

Only prescriptions issued by registered doctors of medicine and dentistry will be honored.

The enclosed form is the result of careful study of a joint committee appointed by the Kansas Medical Association and the Kansas Dietetic Association and has been accepted by this board. Our registrars are instructed to follow this form in detail when issuing additional allotments.

It is the hope of this board that these regulations will help to simplify our mutual problem. Also, it is the intention of this board in every way to feed those who are ill, and it is no intention on our part to deny them the necessity of regaining their health. Please stress this fact: Use of fresh fruits and vegetables whenever possible is necessary for a successful rationing program.

REGULATIONS FOR SPECIAL DIETS

Approved by the Kansas Medical Society and Kansas Dietetic Association for doctors' use in making application for additional points for patients requiring more rationed foods than are allotted by the Office of Price Administration.

DIABETES MELLITUS:

- 1. Meats—No additional points. (Any patient requiring 1 to 1½ grams of protein per kilogram of body weight per day will be amply supplied by the 16 weekly allotted points.)
- 2. Butter—If diet has more than 60 grams of fat, additional points will be necessary.

If fat is 100 grams the patient will need ½ pound butter additional weekly.

If fat is 150 grams the patient will need $1\frac{1}{4}$ pound butter additional weekly.

If fat is 200 grams the patient will need 2 pounds butter additional weekly.

3. Fruits and Vegetables—no extra points for carbohydrates is necessary when fruits and vegetables are in season. When they are not in season:—Four (4) 1

pound cans of fruits and vegetables will be allowed additional weekly maximum.

PREGNANCY, TUBERCULAR CASES:

- 1. Meats and Butter—2 pounds meats and fats additional weekly maximum.
- 2. Fruits and Vegetables—No extra points for carbohydrates is necessary when fruits and vegetables are in season. When they are not in season:—Four (4) 1 pound cans of fruits and vegetables will be allowed additional weekly maximum.

ULCER, BLAND, AND GASTRITIS:

- 1. Meats and Butter—2 pounds meat and fat points additional weekly maximum.
- 2. Fruits and Vegetables—Two (2) 1 pound cans additional weekly maximum.

ANEMIA, ACID ASH, NEPHROSIS:

- 1. Fruits and Vegetables—no additional points.
- 2. Meats and Fats—1½ pounds additional weekly maximum. (In most cases of anemia liver extract medications can be substituted.)

HIGH CARBOHYDRATE—LOW FAT DIETS:

1. Sugar—1³/₄ pounds additional weekly maximum.

(Note)—1. These cases will be considered individually.

2. Prescriptions should be accompanied with information stating foods patient is clinically sensitive to as well as foods patient is not allergic to.

NO ADDITIONAL POINTS WILL BE ISSUED FOR THE FOLLOWING:

Anti constipation Normal children's diet

Obesity

High vitamin

Low protein

Low salt

Hyprtension

Arthritis

Debilitation

IMPORTANT: All allotments will be issued for a 2 month period. Applications in our files will be renewed at the request of the patient according to the above regulations.

DEATH NOTICES

Dr. John H. O'Connell, 59 years of age, died of coronary occlusion on May 23 at Stormont Hospital in Topeka. He was born in Sedalia, Missouri, and was graduated from the St. Louis University School of Medicine in 1909 and served in World War I as a lieutenant in the Medical Corps. He was a member of the Shawnee County Medical Society of which he was treasurer at the time of his death.

Dr. Arthur W. H. Seiple, 74 years of age, of Larned, died on May 10 after an extended illness. He was graduated from the Atlantic Medical College of Baltimore, Maryland, in 1898 and was a member of the Pawnee County Medical Society.

Dr. Frank Winfred Shelton, 68 years of age, died on May 15 at his home in Independence. He was born in Miami County on May 7, 1876, and was graduated from the Kansas City Medical College in 1904. He served as a Captain in World War I. He was a member of the Montgomery County Medical Society.

JUNE, 1944 215



IN THE Progressive NUTRITIONAL NEEDS OF GESTATION

While it is not strictly true that the gravid woman must "eat for two," nutritional requirements nevertheless are higher during pregnancy. As the fetus increases in size, its nutritional demands increase. In consequence, food consumption must be progressively raised to prevent catabolic breakdown of maternal tissue to satisfy these needs.

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ing pregnancy. This delicious food drink proves appealing during this period when anorexia may seriously curtail food consumption. It supplies the nutrients especially required for proper fetal growth—minerals, vitamins, and biologically adequate proteins. Prescribed during the second and third trimesters, Ovaltine helps promote a state of optimum nutrition in the mother and optimum development of the fetus.

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CARBOHYDRATE :	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT:	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS	.25 Gm.	.903 Gm.	NIACIN	3.0 mg.	5.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg
*Each serving mad	e with 8 c	z. of milk; l	based on average repo	rted values	for milk.

MEMBERS

Dr. Charles F. Taylor of Norton was one of the guest speakers at the annual meeting of the American Academy of Tuberculosis Physicians held on June 13 at the Palmer House in Chicago, Ill.

Dr. D. B. McKee of McCune has recently announced that he plans to move to Pittsburg by the first of September. Dr. McKee has practiced in McCune since 1928.

Dr. Fred Morley of Kansas City was elected Vice-President of the Association Railway and Industrial Physicians and Surgeons of Kansas City at their meeting held on May 8, 1944.

Article number XII, Psychiatric Treatment, of the serise of articles published in the Journal on Fundamentals of Psychiatry by Dr. William C. Menninger of Topeka was abstracted in the April issue of Digest of Treatment.

The May issue of Digest of Treatment published an abstract of the article "Treatment of the Psychoneuroses of War" by Dr. Robert P. Knight of Topeka which was first published in the Journal in August, 1943.

The Current Medical Digest of February, 1944, abstracted the article "Peptic Ulcer, An Endocrine Disease" by Dr. John A. Crabb of Topeka which was first published in the November, 1943, Journal.

COUNTY SOCIETIES

At a meeting held on April 12 in Iola, the Allen County Medical Society members conducted an open discussion on medical service plans.

The Clay County Medical Society held a meeting in Clay Center on May 17. Dr. T. C. Kimble, official delegate to the state meeting, gave a comprehensive report on the activities of the Society.

The Harvey County Medical Society met at Newton on May 1. Dr. Herbert J. Rinker of Kansas City, Missouri, spoke on "Allergy."

The members of the Johnson County Medical Society, the Johnson County Health Unit and the physicians associated with military units in the Kansas City area were guests of the staff of the Naval Air Station Hospital at Olathe recently. Dr. Frank Dickson of Kansas City, Missouri, spoke to the group on "Simple Fractures" and Dr. Joseph E. Welker of Kansas City, Missouri, discussed "Hypertension."

The Sedwick County Medical Society were hosts to the members of the Sixth Councilor District at a dinner meeting held in Wichita on May 2. The following appeared on the program: Dr. Warren F. Bernstorf of Winfield; Dr. J. L. Lattimore of Topeka spoke on "Survey of

CLASSIFIED ADVERTISEMENTS

FOR SALE—Office equipment of retiring physician engaged in general practice including complete line of instruments, instrument tables (2), sterilizer, anesthesia table, sterile cabinets, irregator stand, centrifuge. Everything in the best of condition. Write C-O-6—The Journal.

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FOR SALE—Office equipment of retiring physician engaged in general practice. Located in good college town of fifteen thousand, in Kansas. Address Journal C-O-X.

FOR SALE—Large assortment general surgical and bone instruments. Cold quartz and carbon lamps. Bone engine, splints, etc., all about as good as new and prices about 15 per cent of cash. Tell me your needs and let me quote price. C-O-12—Journal office.

FOR SALE—Two used examination tables, and three wood, leather-padded, treatment benches. No reasonable offer refused, write: C-O-5.

FOR SALE—Tonsil and adenoid outfit in good condition at a big reduction. Write—Journal C-O-10.

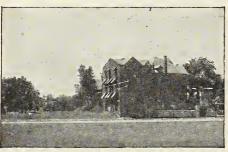
FOR SALE OR LEASE—Kansas physician's and surgeon's practice on account of death; established 40 years; good steady income; equipment included; excellent opportunity. Write Journal of the Kansas Medical Society—C-0-17.

FOR SALE—Because of health must relinquish good practice and lease of small modern Kansas hospital. Good opportunity with no overhead expense. Address Journal C-O-15.

FOR SALE—General practitioner's office equipment, including some hospital furniture. Two large roll top desks with chairs; 1 filing cabinet, universalmode, Thompson-plaster electric cabinet, a two unit electric sterilizer with white enamel cabinet, 2 large instrumnt cabinets, 2 large laboratory tables with marble tops, 38 units of sectional bookcases, library of 260 medical books, a Bausch & Lomb microscope, 4 non-crank type hospital beds and stands, two examining tables, some hospital linens, surgical instruments, including some very good proctology instruments, a hand suppository machine, a centrifuge and bound copies of the Journal of the American Medical Association from 1906 to 1924. Write C-O-16.

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The broadening therapeutic application of estrogenic hormones is well documented by acceptance of the Council on Pharmacy and Chemistry of uses which, in some instances, were unheard of five years ago. At present the accepted uses include the following:

Menopausal symptoms . . . Senile vaginitis Kraurosis vulvae . . . Gonorrheal vaginitis of children . . . Painful engorgement of the breasts in puerperium . . . Carcinoma of prostate . . . Functional uterine bleeding of probable endocrine origin . . . Suppression of lactation under certain conditions.



Amniotin—a solution of natural estrogens—is available in a variety of dosage forms and potencies. For certain other uses, such as in the suppression of lactation and the

checking of functional uterine bleeding, the high activity of orally administered Diethylstilbestrol commends itself. Diethylstilbestrol Squibb likewise is available in a variety of

dosage forms. Recent reports¹ suggest that the nausea which frequently accompanies its initial use becomes less serious as patients gain a tolerance to its administration.



¹Jl. Clin. Endocrinology 3:648, Dec. 1943.

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Problems We Face"; Dr. Harold H. Jones of Winfield spoke on "Post Graduate Education in Kansas"; Mr. Kirke Dale of Arkansas City discussed "Some Aspects of Legislation Affecting Medicine" and Dr. Barrett Nelson of Manhattan explained "A Prepayment Surgical Benefit Plan for Kansas." At a business meeting the following were elected to take offices in the society on January 1, 1945: Dr. N. L. Rainey as president; Dr. B. P. Meeker as vice-president; Dr. H. E. Hiebert as secretary; Dr. A. L. Ashmore as treasurer; Dr. J. D. Clark, Dr. A. W. Fegtly and Dr. J. E. Wolfe as members of the board of directors and Dr. R. A. West as censor.

The Labette County Medical Society held a business meeting in Parsons on April 26 to discuss the proposed issues facing the state medical profession.

The Linn County Medical Society held a business meeting in Mound City on May 1.

The members of the Montgomery County Medical Society held a meeting in Coffeyville on April 19.

ANNOUNCEMENTS

The war-time graduate and regional meeting of hte American College of Physicians will be held in Denver, Colorado, on June 22-24, 1944. All medical officers of the armed forces, Fellows and Associates of the American College of Physicians and other civilian physicians are invited to attend. Dr. Harold H. Jones of Winfield is the Governor for Kansas. Reservations for the meeting should be made through Dr. B. J. Murphey, 814 Republic Building, Denver, Colorado.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

THE UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

The Ninth Annual Assembly of the International College of Surgeons will be held on October 3-5, 1944, at the Benjamin Franklin Hotel in Philadelphia, Pa. The program will be devoted to war, rehabilitation and civilian surgery, with eminent surgeons in government, military and civilian practice participating. The medical profession is invited to attend the assembly and its session, according to word from Dr. Moses Behrend, Chairman of the meeting, who can be addressed at: 1738 Pine Street, Philadelphia, Pennsylvania.

The Annual Meeting of the Association of Military Surgeons of the United States will be held at the Pennsylvania Hotel in New York City on November 2-4. Addresses will be made by the Surgeon General of the Army, Navy and United States Public Health Service and other distinguished guests and the program will be composed of formal papers, panel discussions and scientific and technical exhibits on the latest advances in military medicine.

The American Congress of Physical Therapy will hold its twenty-third annual scientific and clinical session on September 6-9, 1944, at the Hotel Statler in Cleveland, Ohio. The annual instruction course will be held from 8:00 to 10:30 a. m. and from 1:00 to 2:00 p. m. during the days of September 6-8. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. For information concerning the instruction courses and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago 2, Illinois.

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OFFICIAL PROCEEDINGS

TO THE HOUSE OF DELEGATES:

As Treasurer of your Society, I herewith submit financial statement of the Riverview State Bank of Kansas City as of May 2, 1944, and of the Central National Bank of Topeka as of March 31, 1944. In the Riverview State Bank where your General and Defense funds are carried, you have a cash balance of \$21,692.37. Your expenditures in this fund for the year were \$11,743.10. The Journal account carried in the Central National Bank of Topeka shows a profit of \$504.00 for the year and you have a cash balance in that bank of \$2,066.05 as of March 31, 1944.

I have in my possession U. S. Treasury bonds due February 1, 1947, face value of \$10,000 and cash value as of May 2, 1944, of \$8,800.

Total assets\$32,558.42

A very satisfactory condition in my judgment in consideration of the fact that we have had a considerable increase in operating expense and in loss of dues of members who have entered the war effort. Your Defense Fund expenditures for the past year have consisted principally of retainer charge of \$75.00 each month with total expense for Defense of \$920.05 for the year.

Respectfully submitted, GEO. M. GRAY, M.D. Treasurer

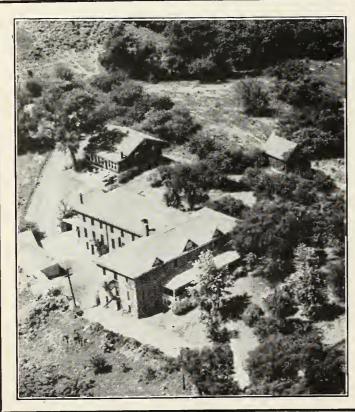
FIRST SESSION OF THE HOUSE OF DELEGATES

The first regular session of the House of Delegates was held at the Municipal Auditorium in Topeka on Wednesday, May 10, at 9:00 a. m. Dr. John L. Lattimore, President, called the meeting to order. It was announced that the minutes of the last meeting had been published in the Journal and they were accepted by vote.

Dr. A. W. Fegtly announced the presence of forty-eight members; forty being a quorum, the meeting proceeded.

Dr. Fegtly read the report of the Committee on Constitution and By-Laws and recommended changes as follows:

- 1. Provision for recommendation to American Medical Association for Affiliate Fellowship by qualified honorary members.
- 2. Provision for Associate Membership in the state Society.
- Provision for election of Delegates-Elect to the American Medical Association with limitation of tenure of office.
- 4. Changes in stipulated "Order of Business" to conform to present system of reference committees and also provide definite "Order of Business" for the last meeting of the House of Delegates.
- 5. Changes in chapter defining committees and committee appointments to include present system of reference committees for briefing certain reports. Some discussion; Dr. Fegtly was asked to make some changes.
- 6. Addition of three special committees whose work has been successful and profitable and should be made standing committees with definition of details of each committee.
 - 7. Amendment requiring state licensure of members.
 - Dr. Belknap read the report of the reference committee



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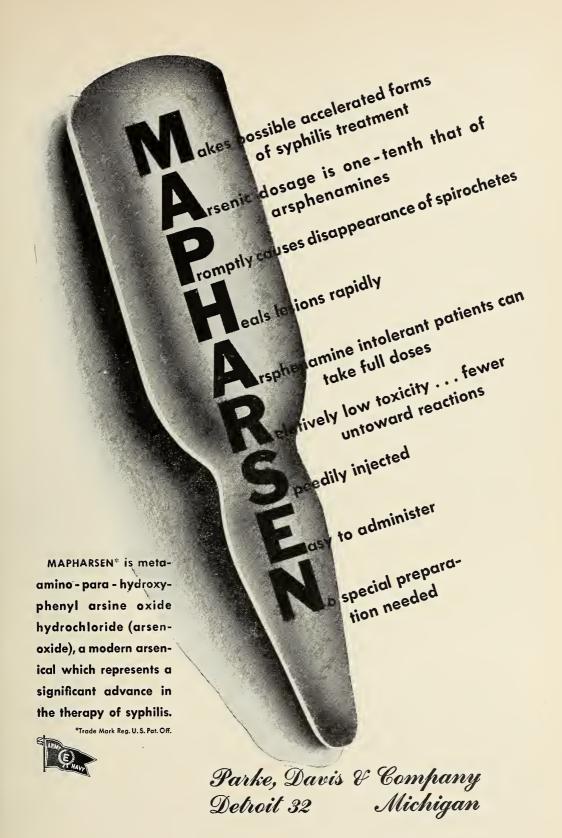
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on all other committees; moved, seconded and carried that they be accepted.

Dr. Lattimore announced that Dr. B. A. Nelson, chairman of the Committee on Medical Economics would be ready to answer all questions concerning the progress of the proposed medical service plan. There appeared to be so much discussion necessary and the time was growing so short, that it was moved, seconded and carried, to postpone this discussion until the second meeting.

The report of the executive secretary was read by Mrs. Margaret R. Foster, acting executive secretary. The report was accepted and a vote of thanks given her for accepting so willingly the responsibility which has been added to her work. Dr. Lattimore expressed his gratitude for the immense amount of work she has done and stated that only those close to the office know what she has accomplished. Dr. Croson added praise to Mrs. Foster for her fine work. He also said that the Society owes a debt of gratitude to Dr. Lattimore for giving so much of his time and energy during this critical situation.

The secretary had no prepared report, stating that the affairs of the Society had been handled by the central office.

Dr. J. F. Hassig, acting treasurer, was absent, so his report was postponed.

Dr. Lattimore had no prepared President's report, but expressed his tremendous appreciation for the committees which have worked during the year. Several committees have had very much work to do—others, because of war conditions, have had little to do.

Report of the American Medical Association Delegates was given by Dr. F. L. Loveland; he had no prepared report but stated that the outstanding thing in regard to the last meeting was the current feeling which moved throughout the entire House of Delegates with reference to the socialization which is going on.

Dr. Lattimore commended Dr. Karl A. Menninger for the fine report of the Committee on Medical History and quoted some of his recommendations.

Dr. Lattimore also thanked Dr. Tihen for his fine work in an advisory capacity.

The election of Mr. Oliver E. Ebel to the position of executive secretary was announced; he will take office about July 1.

Dr. Marion Trueheart was asked for a word as President-Elect, and said he only hoped his year would be as successful as Dr. Lattimore's.

Dr. Ray Gelvin gave a short report of a special committee which was appointed to investigate the possibilities of group insurance for Kansas physicians. Dr. Lattimore explained that during his year as President, he has learned of several formerly active physicians who are practically destitute because of the lack of any such personal insurance. It was pointed out that it is only necessary for the House of Delegates to vote in favor of the plan, then the whole matter of securing contracts will rest with the insurance company, there being nothing mandatory about this plan. It was moved, seconded and carried that the insurance plan be endorsed.

Dr. C. H. Benage had been asked by Dr. Lattimore to make a brief survey of the different agencies setting up offices in Washington, who are continually asking for endorsement by the state societies. He reported briefly on the activities and purposes of: the American Medical Association, the National Physicians Committee, the United Public Health League and the Association of American Physicians and Surgeons. It was moved, seconded and carried that a blanket endorsement of all these agencies be voted.

Lt. Col. William S. Keller, Senior Surgeon, USPHS, Regional Medical Officer of the Office of Civilian Defense spoke briefly on the subject of emergency medical service which has been established by the OCD. He stated the opinion that it is only good sense for the local medical societies to take over this service at the transition period, then it can be allocated wherever the society chooses. Thus it won't go by default as it did following the last war. It was recommended that a committee be appointed to cooperate with the OCD and that this committee contact Lt. Col. Keller about the details.

A letter from Dr. Geo. M. Gray was read, asking that he be voted an Affiliate Fellowship in the Amedican Medical Association. This was done, unanimously.

Adjournment followed.

SECOND SESSION OF THE HOUSE OF DELEGATES

The second session of the House of Delegates was held at the Municipal Auditorium in Topeka on Thursday, May 11, at 4:00 p.m.

Dr. John L. Lattimore, President, called the meeting to order. Representatives from councilor districts four, five, nine and eleven were asked to elect councilors.

Dr. Fegtly was asked to read in brief form, the recommendations of the Committee on Constitution and By-Laws. They were voted on as follows:

1. Provision for recommendation to American Medical Association for Affiliate Fellowship—passed.

2. Provision for Associate Membership—defeated.



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- 3. Provision for election of Delegates-Elect to American Medical Association; first half passed; second half (tenure of office) defeated.
 - 4. Changes in stipulated "Order of Business"—passed.5. Changes in definition of committees and appointments
- —passed.
 - 6. Addition of new committees—passed.

7. Amendment requiring state licensure—passed.

Dr. B. A. Nelson gave a short resume of the necessity felt by most members, for some form of pre-payment medical and surgical plan. He cited the proposed FSA plan of two years ago, which was discovered to be vicious and was refused.

Dr. Nelson moved that the House of Delegates go on record as approving the plan for medical care, that the President be directed to appoint a committee to work out the details of this plan and with the advice of the councilors, based on experience of other plans, to decide how much coverage there should be. The board of directors shall be made up from representatives from each councilor district. Motion was seconded. Discussion was called for and there were two or three different opinions voiced.

Dr. F. L. Feierabend, Secretary of Surgical Care, Inc., of Kansas City, gave a very stirring and convincing talk on the merits of such a plan. He pointed out the dangers of allowing medical service to become a political plaything. He gave actuarial and financial details and stated that their plan has now been accepted by the House of Delegates of the Missouri State Medical Association. He told of the questions asked directly of Dr. Parran at a recent meeting in Kansas City: was he in favor of Senate Bill 1161? No. Was he in favor of socialized medicine? No. Would he administer this if it becomes a law? Yes, because it would be his duty. He went on record as not being in favor of

"medical care by the bureaucrats, but what are the doctors doing?"

Immediately at the close of Dr. Feierabend's address, the House of Delegates voted unanimously to adopt the medical service plan.

Election of officers was the next order of business; the following officers were elected:

President-Elect	Dr. W. P. Callahan
First Vice-President	Dr. W. M. Mills
Second Vice-President	Dr. L. S. Nelson
Secretary	Dr. F. R. Croson
Treasurer	Dr. J. L .Lattimore
AMA Delegate	Dr. J. F. Hassig
Re-elected for t	wo year term.

A letter was read from Dr. Geo. M. Gray, relinquishing the office of Treasurer and expressing his disappointment at not having been able to serve out his planned twenty-five years as Treasurer of the Society. It was moved by Dr. Rombold, seconded and carried that the following resolution be passed:

WHEREAS: George M. Gray, M.D., has rendered a great service to the Kansas Medical Society in his many responsible positions, especially as Treasurer for the past twenty-four years, and

WHEREAS: during that time he has efficiently managed the administration of all funds and given wise counsel and

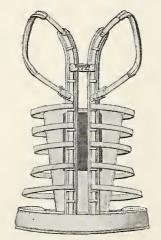
WHEREAS: he has been untiring in his efforts in behalf of the Society and

WHEREAS: he now finds it necessary to retire from his office as Treasurer because of ill health:

BE IT THEREFORE RESOLVED: that the House of Delegates of the Kansas Medical Society in regular session

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convened, extend to Dr. Gray their love and affection, their very deep gratitude and their hope that he will be able to attend many other meetings.

BE IT FURTHER RESOLVED: that one copy of this resolution be spread upon the minutes, one published in our Journal and one copy sent to Dr. Gray.

It was moved, seconded and carried, that the House of Delegates approve the action of the executive secretary committee in electing Mr. Oliver E. Ebel as executive secretary. Dr. Tihen expressed the feeling of the Sedgwick County Medical Society that the state Society is getting an excellent secretary at their loss.

Council District No. Four announced the election of Dr. Frank Foncannon of Emporia; No. Five elected Dr. John L. Grove of Newton; No. Nine elected Dr. J. H. A. Peck of St. Francis and No. Eleven elected Dr. J. R. Campbell of Pratt.

A standing vote of thanks was offered to the Shawnee County Medical Society in their capacity as hosts for this fine meeting.

Adjournment followed.

COUNCIL MEETING

The Council met for the first time in the new year, immediately after the House of Delegates meeting on Thursday, May 11, 1944, at the Municipal Auditorium. All councilors were present.

The Woman's Auxiliary asked for a subsidy; it was moved by Dr. Tihen and seconded by Dr. Bernstorf that they be allowed \$100.00 per year. Motion carried.

Dr. Lattimore stepped down in favor of the new President, Dr. Marion Trueheart. It was moved, seconded and carried, that a rising vote of thanks be given by the

Council for a fine year under the leadership of Dr. Lattimore.

Dr. Trueheart asked for the report of the editorial board. Dr. W. M. Mills, Editor, read the report, stating a surplus of \$2,400.00. Dr. E. H. Decker was re-elected as a member of the board, the names of Dr. Wakeman and Dr. Pyle having been left on, though they are in service. Dr. Tihen moved that thanks be given to Dr. Mills for his fine work on the Journal. Seconded and carried.

Dr. J. F. Hassig reported the activities of the State Board of Medical Registration and Licensure.

It was moved, seconded and carried that the present statute research committee be carried on with Dr. L. S. Nelson as chairman with the possible addition of two or three men whom the President might like to appoint, to continue a study of the legislative program and to report

its findings to the Council.

Adjournment followed.

BOOK NOOK

BOOKS RECEIVED

THE 1943 YEAR BOOK OF PHYSICAL THERAPY—Richard Kovacs, M.D., Professor of Physical Therapy of the New York Polyclinic Medical School and Hospital; attending physical therapist of the Manhattan State, Columbus and West Side Hospitals; visiting physical therapist of the department of Correction Hospitals of New York City and Harlem Valley State Hospital of Wingdale; consulting physical therapist of the New York Infirmary for

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Women and Children, Mary Immaculate Hospital of Jamaca, New York; St. Charles Hospital at Port Jefferson Long Island and Hackensack Hospital at Hackensack, New Jersey. Published by the Year Book Publishers of Chicago, the book is priced at \$3.00.

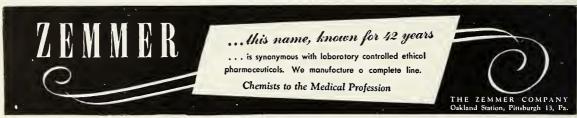
The 1943 YEAR BOOK OF GENERAL SURGERY—Evarts A. Graham, A.B., M.D., Professor of Surgery of the Washington University School of Medicine and Surgeon-in-Chief of the Barnes Hospital and of the Children's Hospital of St. Louis, Missouri. Published by the Year Book Publishers, Inc., of Chicago and priced at \$3.00.

HANDBOOK OF NUTRITION—A symposium prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association, 1943. Published by the American Medical Association the price of the book is \$2.50 and is available from the Association office at 535 North Dearborn Street, Chicago 10, Illinois.

THE 1943 YEAR BOOK OF PEDIATRICS—Edited by Isaac A. Abt, D.Sc., M.D., Professor of Pediatrics of the Northwestern University Medical School; Attending

Physician of the Passavant Hospital; Consulting Physician of the Children's Memorial Hospital and St. Luke's Hospital of Chicago, with the collaboration of Arthur F. Abt, B.S., M.D., Asociate Professor of Pediatrics of Northwestern University Medical School; Associate Attending Pediatrician of the Chicago Maternity Center; Attending Pediatrician of Michael Reese Hospital; Attending Pediatrician of Chicago Maternity Center; Attending Physician of the Spaulding School for Crippled Children and La Rabida Jackson Park Sanitorium of Chicago. Published by the Year Book Publishers, Inc., of Chicago and priced at \$3.00.

THE 1943 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY—Edited by J. P. Greenhill, B.S., M.D., F.A.C.S., Professor of Obstetrics and Gynecology of Loyola University Medical School of Chicago; Professor of Gynecology of Cook County Graduate School of Medicine; Attending Gynecologist of Cook County Hospital; Attending Obstetrician and Gynecologist of Michael Reese Hospital; Author of Office Gynecology and Obstetrics in General Practice and Co-author of the DeLee-Greenhill Principles and Practice of Obstetrics. Printed by the Year Book Publishers, Inc. of Chicago and priced at \$3.00.



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KANSAS MEDICAL ASSISTANTS' SOCIETY

LATTIMORE DINNER PARTY

Dr. and Mrs. J. L. Lattimore entertained the members of the Shawnee County Medical Assistants' Society on April 25 with a dinner party at the Shawnee Country Club. Fifty members and guests were present.

KANSAS MEDICAL ASSISTANTS' MEETINGS

The Sedgwick County Medical Assistants' Society held their monthly dinner meeting on May 17 at the Allis Hotel. Mrs. Harry Dawdy of Topeka, director of Vocational Rehabilitation was the guest speaker. The officers of the society are as follows: Conna Harrison, vicepresident; Catherine Dillon, secretary; Shirley Drake, treasurer. The board of directors members are as follows: Rosalle Anderson, Bernice Bounous, Helen McClain, Virginia Kaelson and Josephine Ackley.

The Shawnee County Medical Assistants' Society held a business meeting and dinner at the Kochi Tearoom in Topeka on May 5. Esther Connors was the installation officer for the following new society officers: Marjorie Euler as president; Alice Galbraith as president-elect; Alma Anstrom as vice-president; Judy Heinsom as secretary; and Hazel Dollard as treasurer. The members of the board of directors are: Mae Evans, Blenda Blankenship and Mary Campbell. Marjorie Euler as the new president conducted the following business: Decision was made to postpone the physicians and wives picnic; and no meetings to be held until September. The new committee chairmen announced by Mrs. Euler were as follows: Attendance Committee-Lydia Preston; Entertainment Committee-Marie Scheetz; Committee on New Membership-Madge Titus; Finance Committee-Blenda Blankenship; Publicity Committee-Charlotte Ellis and Program Committee-Mateel Todd.

The five most common causes of the deaths of school children in the United States are, in the order named, accidents, appendicitis, influenza and pneumonia, rheumatic fever and tuberculosis.—Science News Letter.

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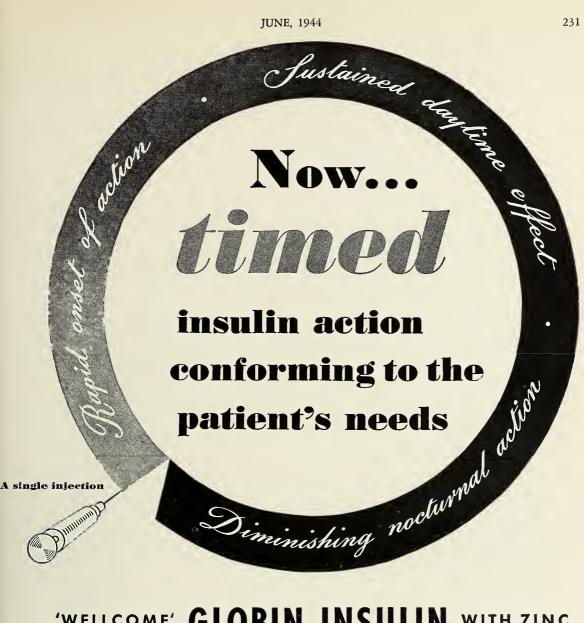
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AUXILIARY

PRESIDENT'S MESSAGE

Helen Keller once said—"We can do anything we want to if we stick to it long enough." We all know that she was a fine example of this statement and if we can dis-

play the same spirit we can reach our goal too.

At our post-board meeting, a printed copy of instructions for the year was distributed. A copy will be sent to the absent members very soon but in the meantime I would like to devote this message to our county auxiliary presidents as they are the ones who have direct contact with the individual member and the one who should be a member. In a previous message, I stated that an Auxiliary is only as strong as each individual member.

This year I would like to have each county president

secure a large note-book and place in it

1. Handbook (will be purchased by the state Auxiliary and mailed to you).

2. Year Book (mailed to you in August).

3. Annual report of state meeting (if you do not have one, write me).

4. Annual report of National meeting (if you do not have one, write me).

- 5. An outline of plans, programs and other activities of your Auxiliary.
 - 6. Clip Auxiliary page from Kansas Medical Journal.

7. National Bulletin.

8. Sample copy of Hygeia.

9. Printed copy of President's instructions.

Next year pass this note-book on to your successor. When I visit your Auxiliary this year, I will be very interested in seeing this note-book.

With the above equipment on hand, may I offer the

following suggestions?

1. Our official year is from the close of May convention to the close of the next annual convention.

2. The state chairmen will send a copy of their plans to you by September 1. Plan your meetings and programs as early as possible.

3. Contact the advisory committee of your local medi-

cal society before undertaking any local projects.

4. Explain duties to your new chairmen (see handbook and constitution and by-laws in the year book) and cooperate with the state chairmen. See that committee chairmen send annual report to state chairmen at date designated by them.

5. It is wise to have a membership drive and collect dues in September when your fall program begins. A physician's wife, mother or widow is eligible for membership. If you live in a county not having an Auxiliary, you may become a member-at-large by sending your dues of \$1.00 to the Auxiliary State Secretary, Mrs. H. L. Regier, 2000 Washington Blvd., Kansas City, Kansas.

A card of membership has been distributed by the National Auxiliary office to the county secretaries to be given members this year when dues are paid. This card entitles you to membership privileges in any medical Auxiliary in the United States. This will be of interest to wives of Army physicians.

6. Dues of \$1.00 per capita with a list of members and their addresses are to be sent to the State Secretary, Mrs.

H. L. Regier by January 1.

7. Send publicity of meetings to State Chairman of publicity, Mrs. E. R. Millis, 1517 Minnesota, Kansas City,

Kansas, by the last day of each month to be included in the Journal Auxiliary page. Would it be possible to have all Auxiliary meetings reported or is such only a dream?

8. Send annual report to me by March 25. Follow

outline pp 8-9 in Handbook.

9. Attend fall board meeting in Salina September 27-28 as guests of the Saline County Auxiliary and of your President. You will be a house guest of a Salina member. We have an interesting social and business program planned for you. Can we have all fourteen county presidents in attendance?

At the state meeting, ten members-at-large paid 1944-45 dues and forty-eight subscribed to the National Bulletin.

This is a splendid beginning—let us continue.

Our Auxiliary programs, public relations, legislative study, war service, etc., all take time but are very worthwhile in supplementing our home duties. Everyone everywhere is busy but try thinking and planning while washing dishes—keep a pencil and pad close by to jot down ideas—it makes dish washing go much faster, I have tried it.

June 11, I leave for Chicago to attend the National Convention. A short visit in Wisconsin with my brothers and sister and then back to Kansas to report to you in the July issue of the Journal all the knowledge and inspiration received at the convention. Good-bye until then.—Mrs. Leo J. Schaefer.

SUBSCRIBE TO THE AUXILIARY BULLETIN

Knowledge is Power—A well-informed person in any walk of life has an advantage over a poorly-informed one and the same is true of an organization. It is as progressive as its individual members.

Our Woman's Auxiliary possesses an official magazine called the National Bulletin. It is published in Chicago four times a year and the subscription rate is one dollar

a year.

This little magazine is full of timely information concerning medicine and its problems and is wirtten in a most interesting manner. It should be on the reading table of every Auxiliary member along with her copies of Reader's Digest, Time, and other publications to which she subscribes in order to keep posted on present-day events.

The articles included in the National Bulletin are educational and can be used as a guide for educational pro-

grams in our local Auxiliary meetings.

With many of our husbands in service, and those remaining working extra hours, it becomes more essential that we be well-informed and able to impart accurate information when the occasion arises in our community organizations and contacts.

There will be many opportunities for service for our organization in the post-war world if we are prepared. Our State President, Mrs. Leo Schaefer, has set a goal for us this year. With a state Auxiliary membership of over 400 women, she feels that we should have at least half that number of bulletin subscriptions in Kansas. We are well on our way with approximately fifty subscriptions received at the luncheon meeting in Topeka during the state medical meeting.

As your State Bulletin chairman, won't you please send me your name, address and one dollar soon so that you will receive the American Medical Association convention number which should be full of information and plans for the coming year. Let's make "every member a reading member"—send in your one dollar for your bulletin subscription today. To—Mrs. F. C. Beelman, 1286 Lakeside Drive, Topeka, Kansas.

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of the

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Number 7

PULMONARY SUPPURATIVE DISEASE: SURGICAL MANAGEMENT*

O. Theron Clagett, M.D.**
Rochester, Minnesota

The pulmonary suppurative diseases include, principally, bronchiectasis, acute and chronic pulmonary abscess and infected pulmonary cyst. Although they are not uncommon conditions and are encountered by every physician, regardless of his field of special interest, they are a badly neglected group of diseases. It is generally assumed that patients who have a chronic, productive cough which is not due to tuberculosis are not seriously ill. Frequently little attempt is made to arrive at a more accurate diagnosis than chronic bronchitis, and treatment often is limited to a prescription for a cough syrup and the suggestion that a change of climate might be beneficial. The patient with a pulmonary suppurative disease does not deserve such casual treatment. The seriousness of these diseases must be appreciated so that they will not be neglected as they have been in the past. Methods are now available which make possible the accurate diagnosis of these conditions and successful treatment of the various pulmonary suppurative diseases has been developed. Successful treatment without excessive risk, however, requires earlier diagnosis than generally has been made in the past so that treatment can be instituted at the optimal time rather than after serious complications have developed. The various pulmonary suppurative diseases produce clinical symptoms that are similar in many respects but the etiology and treatment of each of these conditions is varied. There will be so much to say concerning bronchiectasis and pulmonary abscess that I shall merely touch on the subject of infected cyst of the lung.

BRONCHIECTASIS

The word "bronchiectasis" means bronchial dilatation and is descriptive of the disease to which it is

attached, since bronchiectasis is characterized by cylindrical or saccular dilatation of the bronchi. Although the condition was accurately described by Laennec¹ in 1819, not until a century had passed were methods of accurate diagnosis available, as will appear.

Etiology and Incidence.—There are numerous theories and opinions regarding the etiology and pathogenesis of bronchiectasis. I shall not go into the subject at length. It seems likely that in some cases the condition may be congenital but the evidence to date indicates that in most cases it is acquired. In nearly all cases there is a history of one or more attacks of bronchopneumonia or of a disease or diseases associated with respiratory complications which occurred in childhood. In table 1 are listed some of the conditions which were believed to play a part in the development of bronchiectasis in 471 proved cases encountered at the Mayo Clinic from January 1, 1935, to December 31, 1942, inclusive. Much of what will appear in subsequent paragraphs on the subject of bronchiectasis will be based on this series of cases. The bronchi of children are much more vulnerable to inflammatory processes than are the bronchi of adults and it seems likely that these diseases cause bronchial changes which destroy the normal protective mechanisms of the structure and leave them with impaired function and reduced resistance to infection. On this basis, a vicious cycle develops; the bronchi become more and more susceptible to infection and, as the infection progresses, the cilia, the bronchial musculature, the cartilage and,

TABLE 1		
Causes of Bronchiectasis;	; 471 Cases	•
	Cases	Per cent
No definite cause noted	194	41
Pneumonia	117	25
Whooping cough	44	9
Cold	39	8
Influenza	34	7
Postoperative	14	3
Foreign body	14	3
Measles	8	2
Scarlet fever	3	
Lung abscess	2	
Trauma	2	

^{*} Presented before the annual meeting of the Kansas Medical Society in Topeka, May 11. 1944.

** Division of Surgery, Mayo Clinic.

finally, the nerve endings, are destroyed by the infection. Then, since the normal means of expelling secretions from the bronchial tree are no longer functioning, the infected secretions form pools in the bronchi and produce further dilatation of the bonchi and infection of the surrounding pulmonary parenchyma. Then appear more and more evidences of chronic suppuration, with recurring bouts of fever, anemia, loss of weight and so forth.

Because so much has been written about the association of bronchiectasis and sinusitis, this subject should be mentioned briefly. Bronchiectasis usually begins in childhood and sinusitis usually develops later. Careful surveys, made at the clinic and elsewhere, of cases in which bronchiectasis and sinusitis coexisted have shown that symptoms of bronchiectasis almost invariably antedated symptoms of sinusitis by several months or years. It is the definite opinion among members of the staff on which I serve that sinusitis is much more likely to develop secondarily to bronchiectasis than it is to be etiologic of bronchiectasis. In many cases, sinusitis which has resisted all methods of treatment has subsided completely without treatment after resection of a bronchiectatic lobe.

Bronchiectasis afflicts with about equal frequency persons of both sexes. In the 471 cases previously mentioned, 236 of the patients were males and 235 were females. Bronchiectasis of some degree is found in the course of about two per cent of all necropsies and it ranks next to tuberculosis as a cause of chronic pulmonary infection. Bronchiectasis is essentially a disease of children and young adults. Hedblom² wrote that in his experience only seven per cent of the patients were more than forty years of age and he pointed out that this indicates the seriousness of the disease. It is difficult to determine accurately the age at onset or the duration of the disease because, in many instances, the onset of symptoms is indefinite and the course of the disease is so marked by remissions and exacerbations. In table 2 the ages of the patients at onset are indicated as accurately as they could be determined.

Symptoms.—Bronchiectasis is characterized clin-

TABLE 2 Ages of Patients at Onset of Symptoms of Bronchiectasis;

		4/1 Cases	
_	Age, years	Patients	Per cent
	0-10	227	48
	11-20	87	18
	21-30	55	12
	31-40	45	10
	41-50	38	8
	51-60	8	2
	61-70	8	2
	71-80	3	0.6

ically by a chronic cough that is productive of purulent sputum. The quantity of sputum raised varies considerably with the individual, depending on the duration and extent of the disease. Bronchiectatic patients have little resistance to acute infections of the upper part of the respiratory tract and have a great deal of difficulty in getting rid of these infections. There is usually a marked increase of cxpectoration when these infections are present. In the series of cases on which this portion of the present paper is based, 139 patients, or thirty per cent, raised six ounces (about 180 c.c.) or more of sputum daily. Two hundred ten patients, or forty-four per cent, raised from two to six ounces (about 60 to 180 c.c.), and only twenty-six per cent raised less than two ounces. The sputum often has a foul odor and this, together with the constant cough, often makes the patients social outcasts. Hemoptysis is common; it occurred in forty-two per cent of the 471 cases. Hemoptysis is found much more frequently in association with bronchiectasis than in association with tuberculosis. In some cases of bronchiectasis hemoptysis is the chief symptom and large hemorrhages are of not uncommon occurrence. Victims of bronchiectasis often have fever of low grade, with marked elevation of temperature whenever there is an exacerbation of the process; they are usually anemic and thin. Dyspnea is an occasional subject of complaint. On physical examination, there are numerous coarse rales over the affected region, and dullness to percussion. Clubbing of the fingernails was noted in fifteen per cent of the cases in the present series. It should be noted that clubbing of fingernails is a late sign of bronchiectasis, however, because seventy per cent of that part of the patients of the series who had clubbed fingernails, had such extensive bronchiectasis that curative treatment was impossible. In table 3, the presenting symptoms in the series of 471 cases are recorded.

463	98
198	42
89	19
89	19
36	8
12	3
70	15
	198 89 89 36 12

Diagnosis.—Diagnosis of bronchiectasis is not difficult in most cases. The condition should be suspected in any case in which there is a chronic, productive cough. The appropriate studies to diagnose bronchiectasis include examination of sputum to rule out tuberculosis, actinomycosis, and so forth; roent-

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genologic studies of the thorax; bronchoscopy and studies of the bronchial tree with lipiodol; routine examinations of the blood and urine, and any other studies indicated by the history and physical examination. In the experience at the clinic, it has been possible to diagnose bronchiectasis from an ordinary roentgenogram of the thorax in seventy-six per cent of cases. For an accurate diagnosis of the situation and extent of the bronchiectasis, it is necessary to carry out bronchoscopic examination and studies with lipiodol, however. Bronchiectasis can occur in any lobe of either lung or in any combination of lobes; therefore, it is important to examine both lungs thoroughly. There is not much to be gained by removal of one diseased lobe if one or more other diseased lobes are allowed to remain. Complete physical examination and appropriate laboratory studies should be made to determine the presence or absence of associated diseases, but physical findings are unreliable guides to the extent and situation of bronchiectasis. In the series of cases here considered, the situation and extent of disease, as determined by studies with lipiodol and bronchoscopic examination, are indicated in table 4. The high incidence of involvement of the lower lobe of the left lung is apparent and it is likely that the anatomy of that lobe is responsible for this. The left bronchus comes off the trachea at a more acute angle than does the right bronchus and this may cause some obstruction of the bronchus under some circumstances. It is interesting to note in passing that the incidence of bronchiectasis in cases of situs inversus is high. Adams and Churchill3 reported that 21.7 per cent of all patients with situs inversus admitted to the Massachusetts General Hospital had bronchiectasis although bronchiectasis was the cause of only 0.3 per cent of all admissions to the hospital. Olsen4, at the Mayo Clinic, found bronchiectasis in seventeen per cent of eighty-eight cases of situs inversus.

_				
c.		TABLE 4		
31	tuation and	Extent of Bronchiece	tasis; 202	
				Per cent
		_	Cases	of 202
		Upper lobe	4	
Right lung	Middle lobe	3		
1	ight fully	Lower lobe	39	19
		Entire lung	4	
		Upper lobe	2	
L	eft lung 🧸	Lower lobe	71	35
		Entire lung	8	
Both lower lobes			39	19
Extensive, bilateral			15	
Right lower and middle lobes		2		
Left lower lobe and lingula		10		
M	iscellaneous	.,	5	
		_		
	TOTAL		202	

Treatment.—The only effective curative treatment of bronchiectasis which is now available is surgical resection of the pulmonary lobes which are affected. However, to urge an operation of the magnitude of resection of one or more pulmonary lobes is not justified unless convincing evidence can be presented that the risk of operation is less than that incurred by not treating the disease at all or by treating it more conservatively.

Until the introduction of lipiodol, in 1922, means were not at hand for diagnosing accurately the situation and extent of bronchiectasis in living patients. Not until recently has a sufficient number of patients with bronchiectasis been followed over a sufficiently long period of time to allow of prognosis in cases in which bronchiectasis has remained untreated or has been conservatively treated. It now is known, however, that the pathologic changes produced by bronchiectasis are irreversible and that, once bronchiectasis has developed, it is a progressive disease which in most instances will result fatally. Roles and Todd⁵ reported a mortality rate of thirty-eight per cent in 106 cases in which bronchiectasis had remained untreated and the patients had been followed for from three to six years. Perry and King⁶ reported a mortality rate of thirty-one per cent in 260 cases studied over a period of twelve years. The mortality rate reported by Bradshaw, Putney and Clerf⁷ was 34.5 per cent in 171 cases studied over a period of ten years. Another interpretation of Hedblom's figures, which have been referred to previously, is that in only about seven per cent of cases in which bronchiectasis develops in childhood will the patients live to be forty years of age. Head8, in a series of 200 cases, found only a few patients living after forty years of age. Riggins has commented that in his experience the majority of patients with bronchiectasis succumbed to some form of respiratory illness or complication either before, or during, the fourth or fifth decade of life. Drugs, postural drainage, bronchoscopic operations, roentgenologic treatment or change of climate have not appreciably changed the course of bronchiectasis or produced a cure, as far as I have been able to determine.

Besides the mortality of bronchiectasis, another important factor should be considered; that is, the morbidity associated with the disease. The patients are chronically ill; they are anemic and underweight in many instances; they are subject to exacerbations and remissions of their symptoms, with rather frequent attacks of bronchopneumonia. Cerebral abscess or amyloid disease threatens them. They are harrassed by a chronic cough with sputum that often is so foul that, as has been said, they become social outcasts. Because of the objectionable characteristics

of their disease they cannot live normal lives. Only about twenty-five per cent of the patients are able to do full time work. Riggins has noted that seventy per cent of his patients had not married and that 6.6 per cent of those who had married had later separated from their marital partners or had been divorced. Bronchiectatic patients not infrequently commit suicide. Certainly, considering the fate of the bronchiectatic patient, it is justifiable to suggest any surgical procedure which offers a chance of relief if it is not accompanied by an excessively high mortality rate. Although pneumothorax, thoracoplasty, lobectomy by cautery and other procedures have been attempted for bronchiectasis, the only effective treatment thus far is surgical resection of the involved pulmonary lobe or lobes.

The indications for this operation in cases of bronchiectasis can be indirectly quoted from Edwards10 who has stated that any patient between the ages of four and forty years (and occasionally older), who has bronchiectasis that is reasonably localized and that is associated with infection, and who presents no serious general contraindication, should be considered a candidate for radical excision of the involved portion of the lung. The extent of the disease is an extremely important consideration and the entire bronchial tree must be mapped out by studies with lipiodol, as has been mentioned. The most favorable cases are those in which a single lobe is involved but it is possible to perform total pneumonectomy for disease which involves one entire lung and to perform bilateral lobectomy for bilateral disease. The surgical mortality of lobectomy for a reasonably well-localized process is about three to five per cent. Since bronchiectasis usually has its origin in childhood, it is highly desirable that the diagnosis be made as early as possible. Not only do children and young adults tolerate surgical treatment better than older persons but also the disease is more localized and it has not yet had an opportunity to produce its detrimental effect on the remaining pulmonary tissue, the vascular system and the general development of the individual. Furthermore, it has been shown that in persons who are still growing true hyperplasia of pulmonary tissue will develop to restore the function of the removed segment of lung, whereas in adults compensatory dilatation of alveoli, with emphysema, may result.

The preparation for operation is very important. The disease should be in remission and the patient in as good condition as possible. He should be in the hospital for a few days before operation. During this time he should be given sulfadiazine as a prophylactic measure. A careful program of postural drainage should be instituted so that the lung will

be as free of infection and secretion as possible. One or more bronchoscopic aspirations during this period may be indicated in severe cases. A transfusion of blood should be given if the patient is anemic.

I shall not go into the details of the technic of the operation. However, nitrous oxide and ether are administered under positive pressure through an intratracheal tube. The thorax is opened through a long posterolateral incision. A long segment of the fifth, sixth or seventh rib is resected, depending on the pulmonary lobe to be removed, and the pleura is opened. Careful dissection of the hilar structures is carried out and the blood vessels are individually ligated. The bronchus is closed with interrupted silk sutures and the end of the bronchus is carefully covered with pleura. The anesthetist inflates the remaining lobe by positive pressure. The pleural cavity is drained by a catheter connected to a water seal. The thoracic wall is closed in layers. There is no resultant deformity of the thoracic cage. Bronchscopy is performed immediately on completion of the operation to remove all secretion from the bronchial tree. The patient is placed in an oxygen tent when he is returned to his room. The catheter used for drainage is removed in three or four days. The patient usually can be up in a week or ten days and, if complications do not develop, he often is out of the hospital within two weeks. Empyema is not a common complication of the operation.

The results of these operations are most gratifying. The patient is relieved of the cough and foul expectoration that has made him a social outcast. He is rid of the infectious process that has made him chronically ill. Children are permitted normal growth and development not possible in the presence of the disease. These are the most grateful patients a surgeon can have.

PULMONARY ABSCESS

An abscess of the lung can be defined as a localized suppurative process which roentgenologically shows evidence of contamination not due to tuberculosis, bronchiectasis or cyst of the lung. It must be recognized that bronchiectasis can result from pulmonary abscess and usually bronchiectasis is associated with pulmonary abscesses that are of long standing. The seriousness of abscess of the lung is evidenced by the reports of Sweet¹¹, Brunn¹², Cutler and Gross¹³, who have reported mortality rates of thirty-four per cent to thirty-six per cent in series of cases which they have reviewed. The mortality figures they have presented do not take into account the number of "lung cripples" among the survivors who are condemned to a life of chronic invalidism as a result of their disease. Most of the mortality and morbidity associated with pulmonary abscess

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could be avoided if the condition was recognized promptly and treatment was instituted at the optimal time. Unfortunately, delay in recognition and prompt treatment of abscesses of the lung is the rule rather than the exception.

Etiology and Pathogenesis.—Abscess of the lung may result from (1) aspiration or (2) emboli. Pulmonary abscess due to emboli must be rare. The remarkable ability of the lung to cope with emboli and infarction is well known. The vast majority of these abscesses must result from aspiration of infected material into the peripheral bronchi. This is evidenced by the fact that most abscesses follow operations of some kind. It is highly significant that a large proportion of pulmonary abscesses follow operations on the mouth, nose and throat, particularly when general anesthesia has been used. Sweet has reported that in a series of 125 cases of abscess of the lung, forty-three per cent of the abscesses followed tonsillectomy and fifty-six per cent (including the forty-three) occurred in cases in which the patients had undergone operations on the mouth, nose or throat. Only 11.2 per cent of the abscesses followed operations on other parts of the body. In fifteen per cent of the cases the abscesses followed infections of the upper part of the respiratory tract and pneumonia and in 10.4 per cent of the cases no antecedent cause was determined. A few abscesses followed normal deliveries or aspiration of foreign bodies¹¹. Moore¹⁴, in a series of 202 cases of pulmonary abscess, found that in 159 the abscesses followed tonsillectomy performed under general anesthesia. In 100 consecutive cases of abscess of the lung, Whittemore¹⁵ found that in sixty-six the abscess followed operations on the mouth, nose or throat performed under general anesthesia. Pulmonary abscesses occasionally may develop in other ways and from other conditions but there can be little question that most of them result from aspiration of small foreign bodies, blood clots and infected debris into the distal divisions of the bronchi. The bronchus becomes occluded by this material and the lung distal to the obstruction becomes atelectatic. In this atelectatic lung, inflammation develops and necrotizing anaerobic bacteria produce rapid destruction of the distal bronchi, pulmonary parenchyma and blood vessels, producing a cavity surrounded by a wall of inflammatory tissue. The abscesses almost always are near the periphery of the involved pulmonary lobe because only the smaller peripheral bronchi are involved. Obstructing foreign material usually can be evacuated from larger bronchi because massive atelectasis develops, is immediately apparent and can be treated by bronchoscopic aspiration. The visceral pleura over the abscess soon becomes inflamed and adhesions to the parietal pleura develop rapidly, often producing some pleuritic pain.

Pulmonary abscess is not a specific bacteriologic disease in the same sense as are many other abscesses. Usually a variety of organisms are present. All types of bacteria that are found in the mouth and throat are found in pulmonary abscesses and usually several organisms can be cultured from the same abscess. Anaerobic bacteria are the most important since they are responsible for the necrotizing processes that develop so rapidly in many of these abscesses.

Situation.—The situation of pulmonary abscesses is of some interest. As has been mentioned, they almost invariably are situated in the periphery of the involved lobes. They usually present against the thoracic wall at some point but may point toward the mediastinum, diaphragm or an interlobar fissure. About seventy to eighty per cent of them are found in the right lung and thirty to forty per cent in the lower lobe of this lung. The situation of these abscesses supports the theory that they result from aspiration, since the right bronchus comes off the trachea directly, while the left comes off at an angle; hence, aspiration seems much more likely to occur into the right lung than into the left.

Symptoms and Course.—The symptoms of abscess of the lung vary considerably but usually there are no clinical signs or symptoms for days, or even two or three weeks, after an operation or a respiratory infection. The first sign may be a little elevation of temperature, a little chilliness or even an actual chill. There may be a little pleuritic pain, usually over the site of the abscess. Cough then develops. There may be some hemoptysis. The abscess may develop in one of three ways:

- 1. It may spread rapidly through the surrounding lung, with development of overwhelming gangrenous bronchopneumonia, manifested by marked elevation of temperature, severe toxemia and prostration. This condition is often fatal in spite of any treatment.
- 2. In about twenty-five per cent of cases, the abscess may make its way by necrosis into a bronchus large enough to permit adequate drainage and ventilation of the abscess through the bronchial tree. If the abscess can be evacuated in this way, improvement will be rapid after a few days of expectoration of foul sputum and the clinical and roentgenologic signs of abscess will clear up promptly.
- 3. The abscess may partially, but not completely, drain through the bronchus and, although there may be some temporary improvement in the patient's condition, there will continue to be some elevation of temperature, foul expectoration and general malaise. If this condition of inadequate drainage is al-

lowed to persist, all signs of chronic pulmonary suppuration will develop, with chronic cough, foul expectoration, loss of weight, anemia, high sedimentation rate, recurring bouts of fever as the infection spreads, gradual development of multilocular abscesses and extensive bronchiectasis.

This last course is the one followed in the great majority of cases of abscess of the lung.

Diagnosis.—The diagnosis of pulmonary abscess is not difficult in most cases. As has been mentioned, there is usually a history of a recent operation, often under general anesthesia, or recent pneumonia or infection of the upper part of the respiratory tract. Development of a productive cough, with fever, suggests the diagnosis. A roentgenogram of the thorax confirms the diagnosis.

Roentgenographic studies are essential for diagnosis of pulmonary abscess. They provide the most accurate method of ascertaining the situation and extent of the abscess, the presence of complications and the response of the abscess to treatment. There are no physical signs that can be depended on to supply this information. For the surgeon who is planning to drain an abscess, both anteroposterior and lateral views should be taken so that the abscess can be located accurately at the time of operation.

Treatment.—If all pulmonary abscesses were simple and uncomplicated when first recognized, and if proper treatment were instituted promptly, this condition would present little therapeutic difficulty. A simple pulmonary abscess is like an abscess any place; if adequate drainage is established at the right time, the abscess will heal promptly, with excellent results. Unfortunately, either because of failure to diagnose the presence of an abscess or because of prolonged attempts to treat the abscess conservatively, at least seventy-five per cent of the pulmonary abscesses I have seen have been complicated by the presence of empyema, bronchiectasis or gangrenous bronchopneumonia. The treatment of these complicated abscesses of the lung is difficult, dangerous and the end results are not generally satisfactory. Improvement in the results of treatment of pulmonary abscess must come from early diagnosis and prompt treatment, with provision of adequate drainage of the uncomplicated abscess.

To provide adequate drainage does not necessarily require immediate resection of a rib and external drainage of the abscess, however. I do not subscribe to the view that every pulmonary abscess must be drained externally. As has been said, about twenty-five per cent of abscesses of the lung will establish adequate drainage spontaneously and will heal. By bronchoscopic means it is possible to establish adequate drainage in an additional twenty-five or thirty

per cent of cases. The obstructed bronchus can be dilated and the abscess evacuated in this way without having to subject the patient to the discomfort and disability incident to external drainage. Not only can external operation be avoided by this means in many cases but also important information regarding the extent and situation of the abscess can be gained; moreover, not infrequently unsuspected foreign bodies and bronchiogenic tumors have been found. For these reasons, it is believed that bronchoscopy should be carried out in every case in which pulmonary abscess is present or suspected. If there is clinical and roentgenologic evidence of improvement after this procedure, bronchoscopy can be repeated as indicated. If the abscess is situated in a portion of the lung that is inaccessible to bronchoscopic treatment, or if the abscess fails to respond promptly to bronchoscopic treatment, the abscess should be drained externally without delay.

The opinion at the clinic is that bronchoscopy and external drainage are the only effective treatment for uncomplicated pulmonary abscess. Postural drainage is a weak effort and relatively ineffective. None of the drugs—arsenicals, guaiacol or sulfonamides—have been effective. Roentgenologic treatment is useless. Thoracoplasty, pneumothorax and interruption of a phrenic nerve are mentioned only to be condemned.

The surgical management of complicated and uncomplicated pulmonary abscesses must be discussed separately. First, I shall discuss the simple abscess without going into the technical details of external drainage. The abscess, as has been said, should be accurately located by careful studies of roentgenograms in both anteroposterior and lateral views. If the abscess is accurately located, almost invariably an area of symphysis of the visceral and parietal layers of the pleura can be found, so that an operation for drainage of the abscess can be performed in one stage. The operation should be performed with the aid of local anesthesia, so that there is no interference with the cough reflex. The patient should be in a moderate Trendelenburg position so that there will be no danger of aspiration of pus from the abscess into other parts of the lungs. Diagnostic aspiration never should be attempted until after a segment of rib has been resected and the presence of adhesion of the lung to the parietal pleura has been established. The abscess should be opened with a cautery, the contents of the abscess evacuated and the wound packed open so that adequate drainage is established. The abscess usually will heal satisfactorily and rapidly. It is rarely necessary to resort to any type of surgical closure of the bronchial fistula. The effectiveness of this method of treatment is attested by the

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experience of Neuhof and others¹⁶, who have reported 104 cases with only four deaths. Moreover, Overholt and Rumel¹⁷ have reported thirty-five cases of simple abscess with only two deaths, and a rate of complete cure of ninety-four per cent. My own experience corroborates theirs.

The management of complicated pulmonary abscesses which, unfortunately, comprise the majority of such abscesses in my experience is much more difficult and the results generally are not as satisfactory. The type or degree of complication does not parallel the duration of the abscess. Abscess of the lung is not a "chronologic" disease. Serious complications may develop early in the course of the disease or not until the abscess has been present for some time. I have seen abscesses that have been present for several months and were still uncomplicated. On the other hand, abscesses of only a few days' duration may be complicated by empyema or gangrenous bronchopneumonia. Treatment of a complicated abscess of the lung must depend on the type of complication that has developed. The treatment of gangrenous bronchopneumonia is usually unsuccessful. However, even in the presence of this serious complication, occasionally adequate drainage of the abscess has been lifesaving. From a very brief experience with penicillin, I believe it may be helpful in some of these cases. Empyema that results from rupture of a pulmonary abscess into the pleural cavity is a grave complication and requires immediate open drainage, since the empyema invariably is of a foul, putrid type. Often the empyema is total, with almost complete collapse of the lung. In the presence of empyema, the abscess in the lung itself usually heals, since it drains into the pleura with obliteration of the abscess cavity; the lung may reexpand but in some cases extensive thoracoplasty is necessary to obliterate the pleural space. Probably the most common complication of an abscess that is allowed to persist without adequate drainage is the development of multilocular abscess in the lung, or extensive bronchiectasis. Satisfactory treatment in these cases usually requires lobectomy or pneumonectomy. The operation is difficult because of the prolonged suppuration. The lung, in the presence of multilocular abscess or extensive bronchiectasis, usually is densely adherent to the thoracic wall and the hilus of the lung is indurated and matted with inflamed lymph nodes. The operation is necessarily accompanied by fairly high surgical mortality but it is the only curative treatment available. The only alternative is to condemn the patient to chronic invalidism with chronic pulmonary suppurative

I should like to emphasize again that the majority

of pulmonary abscesses have become complicated before they have been recognized and before treatment has been instituted; that failure to recognize abscesses of the lung is responsible for the serious consequences of this condition; that the diagnosis is not difficult if the possibility of the condition is considered; that roentgenograms of the thorax are the only accurate means of diagnosing the presence of an abscess or of ascertaining its situation and its response to treatment; that every patient with a suspected, or proved, pulmonary abscess should undergo bronchoscopy at least once, and that pulmonary abscesses can be treated safely and effectively only if they are recognized while they are still uncomplicated.

INFECTED PULMONARY CYSTS

As I said earlier, a full discussion of infected pulmonary cysts cannot be given at this time. Pulmonary cysts may be congenital or acquired. They may be present for years without producing symptoms or changing in size. They are dangerous, however, because they are likely to become infected at any time and they have little protective mechanism of their own with which to combat infection. Treatment invariably should consist of surgical resection of the cyst. Drainage alone is not curative.

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CONTINUOUS SPINAL ANESTHESIA

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Continuous or fractional spinal anesthesia has been used on our services in three hundred widely varied operative procedures. This experience has shown it to be a method of anesthesia of great practicability and safety. To date there have been no serious complications.

Pre-operative sedation is carefully adjusted so that the patient is quite drowsy when brought to the operating room. The average adult is given three grains of nembutal the night before operation, three grains of nembutal two and a half hours before operation and a quarter grain of morphine thirty to forty-five minutes before operation.

The apparatus first described by W. T. Lemmon is used. This consists of a special thick two piece mattress with a cutout in the center to accommodate the needle and tubing, malleable spinal puncture needles, hard rubber tubing with Luer-lock devices at both ends, and a stopcock at the distal end which is attached to a Luer-lock syringe.

A punch is used to perforate the skin and spinous ligament. The needle is then inserted and ten cubic centimeters of spinal fluid withdrawn. Five hundred milligrams of novocaine crystals are dissolved in the ten cubic centimeters of spinal fluid. The hard rubber tubing, which holds two cubic centimeters, is then attached to the syringe, filled with the anesthetic solution and attached to the needle. At this point it is important to withdraw on the syringe to make sure that the needle remains in place. Ordinarily 100 milligrams (2 cc.) are injected as the initial dose, the stopcock near the syringe closed, and the head of the operating table lowered until adequately high level of anesthesia is attained. The level of anesthesia is secured by this positioning on the table, dose of the anesthetic agent, and by volumetric dilution. In operations above the diaphragm we have used five hundred milligrams of novocaine dissolved in twenty instead of ten cubic centimeters of spinal fluid.

Additional doses of fifty milligrams every thirty minutes or twenty-five milligrams every fifteen minutes are injected. This is usually enough to maintain the anesthesia once the initial proper level has been attained. We have noted that in the severely jaundiced patient more anesthetic is required and have, in one such instance, given 750 milligrams in two and a quarter hours without untoward effect.

In several instances we have used the entire original anesthetic mixture, and then merely withdrawn another ten cubic centimeters of spinal fluid with which to make up additional solution.

When anesthesia is not adequate ten minutes following the initial dose, the tubing connections are inspected for leaks, return flow checked, and an additional fifty milligrams injected. In seven radical mastectomies it has required from fifteen to thirty minutes for complete anesthesia, with an additional fifty milligrams injected every ten minutes.

Many patients sleep during the entire operation. Morphine is given to maintain sedation during prolonged procedures. Post-operatively, the head of the bed is lowered for twelve to twenty-four hours to minimize the incidence of headache.

In our three hundred cases, there has been no anesthetic death and no shock or other severe complication in any way attributable to the continuous spinal anesthetic. During the eighteen month period covered by this report, we have used the single dose method for routine hernia and perineal repairs, hemorrhoidectomies, and appendectomies when we felt that the 125 or 150 milligram initial dose would be perfectly adequate. This was done because the simple spinal anesthetic is slightly easier to administer.

Cases in which continuous spinal has been used were distributed as follows:

Hernia	37
Biliary Tract	40
Gastro-intestinal	
Stomach	24
Appendix	36
Intestine and Colon	26
Gynecologic	
	13
Abdominal-perineal	23
Abdominal	76
Urologic	9
Thoracic	8
Orthopedic	5
Others	3

Nausea and vomiting during anesthesia have been no more frequent than with the single dose method. They usually occur early, when they may be partly due to preoperative medication, or while traction is being made on the mesentery. Both are readily controlled by oxygen inhalation. Fall in blood pressure has in no case been alarming. This also occurs early and during traction on the mesentery, with a near normal systolic pressure recorded almost immediately after traction is released. The average difference between high and low systolic pressure recorded during anesthesia has been 25.2 mm. of

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mercury, and the average fall from beginning to the end of anesthesia has been 15.1 mm. of mercury. It is to be noted that our high recording during anesthesia is invariably higher than the normal systolic pressure for the patient since 50 mg. of ephedrine sulfate is routinely injected with the local anesthetic used at the lumbar puncture site. Actually, the systolic pressure at the end of operation is usually within 10 mm. of the individual's normal systolic pressure. This compares favorably with blood pressure readings during the course of ether anesthesia in similar operative procedures.

In seven radical mastectomies, with anesthesia to or above the level of the clavicle, there was no great fall in blood pressure, and absolutely no interference with normal respiration. This has led us to believe that the blood pressure fall with spinal anesthesia is largely due to the central effect of the large initial dose of novocaine sometimes used in the single dose method, rather than to any paralysis of nerves as they leave the cord. The same applies to interferences with respiration.

Postoperative headaches and respiratory complications have been no more fequent than with the single dose method. In no instance has it been necessary to supplement with inhalation anesthesia. This is occasionally necessary with simple spinal, and has been the source of much difficulty, as one would expect in attempting inhalation anesthesia with a patient heavily sedated in preparation for spinal anesthesia.

The malleable needles are somewhat more difficult to introduce than the ordinary lumbar puncture needle. We were unable to introduce the needle in one elderly man with an advanced osteoarthritis of the spine.

We have used novocaine in all except ten of these cases. Monocaine formate was used in these ten and found to be effective in slightly smaller dosage. These two agents are the least toxic of all spinal anesthetic preparations and should be given prefer-

Dr. W. T. Lemmon has shown that continuous spinal anesthesia has a wide margin of safety. He has reported some 4,000 operations without anesthetic mortality. It is easy to administer, and can be prolonged almost indefinitely without harm. The surgeon finds his work easier with the complete muscular relaxation he is afforded, and the knowledge that he need not hurry for fear his anesthetic wear out. The operative field is practically immobile, without the heaving respiratory movement so frequent with inhalation anesthesia. Patients like this anesthetic, and those who have previously been subjected to ether anesthesia are particularly emphatic in their praise.

Continuous spinal anesthesia is safe, flexible, complete. It can be safely used where any other general type of anesthetic is used for abdominal and thoracic surgery, and also in those cases where liver damage and cardiac abnormalities contraindicate the various inhalation anesthetics. It is our feeling that it is deserving of wider use, and that it is particularly well adapted to the needs of smaller institutions which are without the services of a full time specially trained anesthetist.

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In the last war, the influenza pandemic or universal epidemic was responsible for in the neighborhood of 800,000 admissions to hospitals and for perhaps 25,000 deaths in addition to many deaths ascribed to pneumonia but brought on as a result of influenza infection. With other respiratory diseases, it caused about one-third of the total admissions for disease in 1918, and roughly eighty per cent of disease deaths.

In general, conditions have been better in this war. An outbreak of mild influenza started in December, 1941, and carried over into early 1942 and produced relatively high admission rates. Subsequently, the curve has shown only the expected seasonal variations. Practically no deaths occurred as a resuit of this outbreak.

One form of pneumonia, designated by the Army as "primary atypical pneumonia," showed during the last year. In March, 1942, the Surgeon General called attention to the disease and so designated it. In the first month, there were over 100 cases reported, and the frequency increased to a peak in April, 1943, of about 3,500 cases. Since then there has been some decline. Mortality is low, but the disease contributes heavily to keeping men off active duty, since lesions, demonstrable by x-ray, persist for several weeks. In the Navy, cases of atypical pneumonia ran 1.5 per thousand during the first six months of 1943.—Office of War Information, Report on Health of the Armed Service.

On February 11 the Council on Pharmacy and Chemistry of the American Medical Association entered its fortieth year of service to the public. The recent Journal of the Association said: "Since its first meeting on February 11, 1905, the Council has fought continuously for rational therapeutics. It has created much change in the practice of therapeutics. Its activities and decisions are highly respected and are followed internationally by leading medical authorities; its advice is sought frequently by administrative, advisory and educational bodies in this country and others. . . . It is fortunate indeed for the public and the medical profession that there exists an unselfish body such as the Council which can give scientific consideration to rational therapeutics and issue its statements without fear or favor."

THE MEDICO-LEGAL ASPECTS OF THE TRAUMATIC NEUROSES

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Any consideration of the neuroses must recognize that there are no circumscribed boundaries under which certain types of neuroses may be considered to the exclusion of the rest of the neurotic field. The very fact that the neuroses are not subject to any delimitation but that they present a broad and comprehensive picture of departures from normal trends in thought and reaction, postulates that these classifications must necessarily involve consideration of the entire neurotic picture. The further fact that current authority entertains widely divergent concepts on the subject of the neuroses and psychoneuroses tends further to give an air of uncertainty to any postulation that might be advanced. Therefore, it must be accepted that whatever of material has been presented in support of present concepts is based upon individual interpretations without specific proof of their validity.

For instance, Freud attempted to classify neuroses into a true neuroses in which there is an actual even if temporary physical disturbance within the organism responsible for the neuroses exhibited. In the psychoneuroses he seeks to illustrate regression to infantile levels with the various terminologies which include fixation, transference, conversions, etc. These cannot be assumed as sufficiently specific to constitute a differential foundation as between the neuroses, so-called, and the psychoneuroses. As we must regard all neurotic manifestions as psychogenetic it appears difficult to accept such a differentiation.

Tracing the various steps in an atetmpt to interpret these neuroses from the days of Mesmer until the beginning of the eighteenth century, Charcot was the first to postulate purely psychoneurotic manifestations. His theories as well as his methods of treatment were formulated upon his knowledge of the procedures of Mesmer. Janet developed his theory of dissociation. Later the Wundtian theory of psychophysical parallelism was presented and largely accepted. The school of Jung developed the theory of introversion and oxtroversion as relates to personality types, Bleuler presented his theory of schizoid and syntoid types with the variations in theory advanced by Myerson, Adler, and other investigators.

The elaboration of these various theories constitutes a splendid contribution to the analysis of the psychologic factors involved in all personality deviations resulting in the development of psychoneurotic trends. The most significant of these has been the postulation which has perhaps come nearer to being validated than others, of the significance of our unconscious life and its influence upon motivation. All forms of neuroses may be interpreted either as methods of escape or as attempts to adjust to mental or environmental stresses against which the personality rebels. The main fact to be considered is that whether as an adjustive, a defense, or as an escape mechanism, the psychoneurotic unconsciously resists any attempt to return to a state of proper understanding of those attitudes or conditions from which escape seems desirable. Manifestly there is no possible chance of approaching these deviations from a physical angle. Consequently they must be subjected to a psychological interpretation, uncertain though this may be.

The subject of traumatic neuroses or psychoneuroses occurred to me as one of unusual interest, as a large portion of medico-legal cases in which expert medical opinion is sought belongs to this classification, and because of the difficulties inherent in medico-legal opinion submitted to trial courts or commissions due to the fact that there are so many divergent views expressed. Comparatively little has been written on this subject within the past few years, perhaps because of the lack of delimination of symptomatic phenomena. In one specific factor only does there seem to be provocation for such classification, namely the history of a trauma sustained, following which neurotic or psychoneurotic symptoms not hitherto present have presented themselves.

Are the traumatic neuroses increasing? What effect has the Workman's Compensation Act on the development of these? How are they identified, and from what must they be differentiated? What forms of treatment are available, and their relative value?

It is estimated that the number who fall victim to some form of neuroses more or less disabling in the United States is 750,000 annually. The assumption of a progressive increase in the number of those suffering from psychoneurotic disorders, while unsupported by any statistical figures that have come to my attention, is justified by this apparent increase.

The traumatic neuroses differ fundamentally from most others in that there is apparently a definitely established etiologic factor. The neurotic manifestation does not constitute a flight from reality or elaboration of fantasy formulations as in other types of neuroses, but rather exhibits anxiety and obsessive trends definitely related in the mind of the sufferer to a physical causative factor. As a result these conditions frequently become the subject of medicolegal controversies resulting from the claimant's be-

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lief that his distress is chargeable to a preceding trauma. This conviction is frequently strengthened by ill-timed suggestions of family or friends, or the hope of financial compensation.

It is generally observed that those carrying insurance against sickness or injury recover more slowly than those receiving no compensation. This might seem to imply a desire to realize on the insurance investment, although there are more deeply grounded psychological factors that must be considered. The invalidism of so large a portion of our population due to psychogenic disturbances and the relation of this invalidism to our present day economic and sociologic plan must be given consideration. Neither the prevalence nor the seriousness of psychogenic disorders were fully recognized until their widespread occurrence and profoundly disabling effects were noted during and following the World War period. In recent years it has become a custom to make the neuroses a catchall for conditions, complaints, or symptoms for which organic pathology cannot be readily demonstrated. This custom frequently leads to error, since many organic nervous conditions present in their early inception emotional and temperamental variations which might easily be construed as neurotic.

The effect of trauma on the nervous system presents difficult problems both from a diagostic and medico-legal standpoint. From a diagnostic angle they must be differentiated (1) from organic disease, (2) from other forms of neuroses, (3) from beginning mental disease, (4) from malingering, and (5) from any combination of these. A diagnosis based on the absence of physical or neurologic evidence, the usual criteria for differentiation, is not always dependable, as the absence of determinable pathology does not necessarily prove the existence of a neuroses. Careful and, if necessary, repeated neurologic examinations are sometimes demanded in order to establish or rule out organic factors. A careful history and a search for psychogenic components is as important as the neurologic examination.

History of the onset of symptoms immediately following trauma is presumptive of probable organic injury, while the development of symptoms after a latent period of days or weeks in the absence of sustaining physical or neurologic confirmation is suggestive of a neurosis or malingering. It is, therefore, important to determine the presence or absence of neurotic trends before the receipt of the trauma, as well as to bear in mind that somatic and psychogenic factors may be concomitant. While there is a tendency for neurotic symptoms developing following a trauma to gradually improve, in the event that litigation involving a court decision is undertaken

the impression that the claimant was consciously attempting a form of deception for personal gain is frequently given. However, there are many exceptions in which the residuals of the neuroses continue for years or throughout life in spite of any decision for or against the claimant. It is, therefore, the consensus of opinion that prompt settlement of claims arising from these neuroses is advisable.

TREATMENT

There is no specific therapy. Obviously drugs can have little or no beneficial effect and may even aggravate the condition, as it represents a phychic and not an organic trauma. The most unfortunate complication one encounters is the tendency of the general profession to treat these conditions medically or surgical as organic manifestations. Psychotherapy seems the most satisfactory method at our command, embracing encouragement, reassurance, and diversional efforts.

PROGNOSIS

The prognosis on the whole is more favorable than in other types of neuroses because the provocative background is less involved. In cases where compensation is sought the advantage of prompt settlement may be noted not only in the improved condition of the patient and a progressive trend toward recovery, but avoids certain other hazards. Multiple hearings have an unfavorable influence on the symptoms and treatment of these conditions. In some states a definite and conclusive settlement is not made in a single hearing, but an award is made for a certain period, after which there is another hearing and another award, sometimes continuing for years. This has the effect of crystallizing the dynamics of the neurosis. The possibility of late sequelae must not be overlooked. It is not unusual for convulsive states to develop months or even years following a head trauma. Spinal cord degeneration or optic atrophy may supervene months after a severe electrical shock. Active psychotic symptoms may be precipitated by trauma (traumatic psychosis). Traumatic meningitis or brain abscess may be a late manifestation of head injuries. These may all in their incipient stages closely simulate a neurosis. Extreme care and careful discrimination must be exercised in evaluating the significance of symptoms.

It will be seen from the foregoing discussion of the medical aspects of this condition that its legal facets are many and varied. From the legal standpoint it is recognized that there is a distinct tendency on the part of the plaintiff to exaggerate his disability, consciously or otherwise. The tendency of the defense is to minimize or even deny the existence of a disability or, if admitted as existing, the culpability or responsibility of the defendant.

(Continued on Page 248)

President's Page

To the Members of the Kansas Medical Society:

The United States Chlidren's Bureau has decided that they wish to expand the Emergency Maternal and Infant Care Program to take in any ailments that affect the mother during pregnancy. The Council has been asked to vote on what should be done about accepting this new service.

The thing that bothers me more than anything else is their proposal for consultation service. The deciding questions on this brief were as follows: They request that a Diplomate of a specialty board shall be the consultant; that where no Diplomate resides a specialist shall be employed and where this service is not available the county society must select one of its members to be the consultant.

Since medicine in Kansas is trying to preserve freedom we are proposing an alternative that either several consultants be appointed who shall serve concurrently or in rotation or that we continue according to the present plan whereby we select whoever we wish for consultation.

I feel that any of you who are interested should contact your Councilor and give him your views. It seems to me that the proposed plans are not applicable to Kansas. I do not feel that it would work in this state with our scattered population, especially in the western half of the state.

Yours truly,

President, The Kansas Medical Society

M. Trueheart. M. D.

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EDITORIALS

GREETINGS

Your executive secretary is proud of the honor you have afforded in accepting him in your organization. This, the position of highest responsibility the Kansas Medical Society has to offer any lay person, is a challenge that will be seriously and continually considered.

When he makes mistakes they will be errors in judgment for never will anything precede the interests of the medical profession in Kansas. Toward that end he will serve you to the best of his ability at all times. He will be glad to meet with any member on any subject and welcomes your advice.

The Kansas Medical Society should represent to the people of Kansas the highest in scientific attainment. Kansas has a right to expect your Society to be unselfishly interested in its welfare. The public should depend upon this organization for integrity and leadership. Your secretary will earnestly try to foster that relationship in all parts of the state and to maintain the trust you have been afforded in the past.

With your help, he hopes to retain for you the enviable position this Society enjoys throughout the nation. It is his ambition that your unparalleled accomplishments may continue unbroken into the future. Then, come what may, we will review our efforts with the knowledge that we could have done no more. We will have discharged with interest our obligation toward the public we serve, toward our members now with the armed forces, and toward the ideal that we speak of in the name of the medical profession.—Oliver E. Ebel.

KANSAS SECOND PHYSICIAN WAR CASUALTY

Word has been received in the central office that Capt. Ralph Milton Wyatt, a flight surgeon from Hiawatha, was killed in a plane crash near Aldershot, England on June 8.

Captain Wyatt was born on January 10, 1906, and attended grammar school and Central High School in Kansas City. His brother, Dr. C. H. Wyatt, is a Kansas City, Missouri, physician. He was an active member of the Brown County Medical Society having served as its president and secretary at various times. He enlisted in August, 1942, and was first stationed at Perrin Field, Texas, but was later moved to Enid, Oklahoma. While in Enid he was sent to

Randolph Field and graduated from the School of Aviation Medicine on October 27, 1943. He later attended a school of Tropical Medicine in Washington, D. C., and was sent to England in February, 1944.

The first known Kansas physician war casualty occurred on September 3, 1942, when Captain Raymond C. Stiles, formerly of Kansas City, was killed in an Army transport crash near Coamo, Puerto Rico. Both of these young doctors of medicine had attended the University of Kansas. Dr. Stiles completed his medical education at Baylor University School of Medicine in 1937 and Dr. Wyatt graduated from the University of Kansas School of Medicine in 1933. Both interned in Kansas City, Dr. Stiles at St. Margaret's Hospital and Dr. Wyatt at Kansas City General Hospital. Both captains were killed in line of duty.

Kansas medicine has experienced an irreparable loss in the death of these two active and capable young physicians. Kansas physicians have given willingly and unstintingly of their time and energy and met the medical manpower demands on all fronts, but in the years to come the loss of men such as Captain Stiles and Captain Wyatt will be keenly felt. The members of the medical profession of the state extend to the members of their families their heartfelt sympathy.

CUSHING'S LIBRARY

Of the multiple interests of the late Harvey Cushing no one was more deeply imbedded in his personality than his love of books. Beginning as a student, he built up a library of nearly eight thousand volumes, a collection he bequeathed to Yale University. Certain sections of the library, having particular interest on account of their size or completeness, were to be catalogued by his request. In order to give a complete idea of the whole library, however, the Historical Library of the Yale Medical Library has issued a short-title catalogue¹ of all the books.

To those familiar with Cushing's taste in books, it is not surprising to find the incunabula section and the writings of Paracelsus, Pare and Vesalius filling many shelves. Indeed, one hundred and sixty-eight medical incunabula, with sixty manuscripts, comprise a collection that any medical library would be proud to own. Hardly half a dozen collections of this magnitude exist in America. In addition, Cushing owned over forty editions of books by Pare, sixteen by Paracelsus and more than fifty by Vesalius. The last, the only group carefully worked over by Cushing, have recently been considered in a special study². Other authors, however, are also well repre-

sented: Robert Boyle, sixty-one editions; Nicholas Culpeper, one hundred and ten; Daniel Drake, sixteen; Robert Fludd, nineteen; Samuel Garth, twentyfour; William Harvey, forty-three; Edward Jenner, thirty; Leonardo da Vinci, eighteen; Carl von Linne, thirty-four; Silas Weir Mitchell, forty-three; William Salmon, twenty; and Tobias George Smollett, seven. The longer lists might be supplimented by many important shorter ones, some containing even greater books from the pens of less prolific writers. His contemporaries—Osler, Klebs, Welch, Power, Sarton, Singer and others—are naturally fully represented. Since the surgical texts and periodicals were removed from his library when Cushing left Boston in 1930, the books now catalogued represent those that he thought were worth saving, the result of years of collecting. If an individual library may be said to reflect the man, surely a portrait of Cushing stands out in the contents of this catalogue. Broad interest, complete details, sound universality but exact focal discrimination and "looking all around a problem," to use one of his favorite expressions—in other words, the characteristics of Harvey Cushing-are well mirrored in his carefully selected library.—New England Journal of Medicine.

1. The Harvey Cushing Collection of Books and Manuscripts. Publication No. 1, Historical Library, Yale Medical Library. 207 pp. New York: Schuman's, 1943.
2. Cushing, H. A Bio-bibliography of Andreas Vesalius. Publication No. 6, Historical Library, Yale Medical Library. 229 pp. New York: Schuman's, 1943.

TUBERCULOSIS CONTROL

SMALLPOX VACCINATION AND PULMONARY TUBERCULOSIS

A search of the literature gives little information regarding the possibility of vaccination for smallpox being the causative factor in a subsequent flare-up of latent or active pulmonary tuberculosis. Blacher (1931) has recorded two cases, both in children. In the first of these a boy aged eleven, suffering from dystrophia adiposo-genitalis, developed a tuberculous meningitis following re-vaccination, and from this Blacher concluded that the vaccination had reactivated a pre-existing tuberculous focus. His second case was that of a girl aged eleven, whose skiagram showed a small hard focus in the right upper zone. She was subsequently vaccinated, and ten days later there was fever and x-ray evidence of re-activation of the pulmonary lesion.

Ainger (1937) recorded two further cases where tuberculous meningitis followed immediately on vaccination, and from this he drew the conclusion that either vaccination lowered the powers of resistance. thus paving the way for a fresh infection, or that an inactive lesion already present flared up as a result of the procedure and spread unopposed throughout the lung.

Stone (1931) reported the results following the vaccination of 337 patients at the Robert Koch Hospital, St. Louis. All stages and types of pulmonary tuberculosis were included in Stone's cases, and only one patient showed any definite pulmonary exacerbation, while two others had a temporary increase in the amount of cough and sputum. His view, therefore, was that the presence of pulmonary tuberculosis was not a contra-indication to vaccination.

In the summer of 1942 there was an outbreak of smallpox in Glasgow, and later in the same year in Edinburgh and Fife. Considerable numbers of the public were vaccinated, and one of us (R. Y. K.) received numerous requests from former patients of the sanatorium for advice as to whether, in view of their previous pulmonary infection, they should undergo vaccination. Those living or working in Glasgow were advised without hesitation to be vaccinated, as it was felt that the results of smallpox would be much more disastrous than any post-vaccinal flare-up in the chest. As far as is known, none of those so advised suffered any ill-effects. Later in the year four cases were admitted to the sanatorium, all of whom gave a history of vaccination followed almost imediately by the appearance of symptoms of pulmonary tuberculosis.

CASE RECORDS

Case 1.—Male, aged twenty-eight. This man, an engineer by profession, had an excellent medical history and for years had not been off work for a single day. In June, 1942, he applied for a post abroad, and before acceptance he underwent and passed a medical examination. A condition of his appointment was that he must be vaccinated in this country before departure, and this vaccination was duly carried out by his own doctor in July. Four days following the vaccination he had a severe reaction; he felt feverish and his arm was swollen and tender. After a further three days he developed a sharp pain in the left chest, which proved to be the beginning of an acute pleurisy with effusion. The subsequent skiagram revealed bilateral infiltration with cavitation in the left upper zone. This patient stated most emphatically that prior to vaccination he had felt perfectly well and had been able to do his work, which entailed considerable physical effort, without the slightest inconvenience.

Case 2.—Male, aged twenty-two. This boy gave a history of pulmonary tuberculosis dating from the age of sixteen, for which he had received sanatorium



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and one oils, water colors, drawings and sketches executed for *What's New*, Abbott's house magazine to the medical profession, is open to the public. It is hoped that all friends of Abbott will find it possible to attend. Abbott Laboratories, North Chicago, Ill.

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treatment on several previous occasions, the last being in 1939. Following this he had remained fairly well and had been living quietly at his home for two years, where his main occupation had been fishing. In July, 1942, he was vaccinated and had a severe local reaction with, at the same time, pain in the chest and dyspnea. Radiological examination a few days later showed the presence of a small pleural effusion on the right side together with a fresh area of exudative disease in the mid and lower zones.

Case 3.—Male, aged twenty. This boy had been treated in the sanatorium in 1941 for a left pleural effusion, from which he made a completely satisfactory recovery. He was discharged after a six months' stay and spent the spring and summer of 1942 as junior master in a preparatory school. In the autumn he was in business in Edinburgh, still well and free from symptoms. In November, 1942, he was vaccinated. He had very little local reaction but felt generally "ill," his main symptom being lassitude. He did not feel well enough to return to business, and three weeks later, in addition to the lassitude, he developed a slight temperature associated with the appearance of cough and sputum. Tubercle bacilli were present in the latter, and subsequent x-ray examination showed the presence of a recent area of exudative disease in the right upper zone.

Case 4.—Female, aged nineteen. This girl was working in an emergency hospital as a V.A.D. and was vaccinated along with her colleagues in July, 1942. She had a severe local reaction and was in bed for four days. Subsequently she felt tired and three weeks later had the misfortune to fall victim to a mild epidemic of glandular fever which attacked some of the hospital staff. She recovered rapidly from the fever but the lassitude previously present persisted, and shortly after she had a sudden hemoptysis. Radiological examination showed scattered infiltration throughout the left upper and mid zones, which commencing cavitation immediately below the clavicle.

DISCUSSION AND SUMMARY

In view of the relatively few references to the association between vaccination and pulmonary tuberculosis which we have been able to find it is felt that these cases should be recorded. It is impossible to draw any definite conclusions from isolated instances such as these, but it would appear that there is sufficient evidence here to justify the assumption that vaccination may cause a flare-up in a latent focus.

Our results are at variance with those reported by Stone, but it should be remembered that his cases were under sanatorium conditions at the time of vaccination, while those we have recorded were engaged in their normal occupations, and therefore no more precautions were taken in their cases than would be taken with the average healthy individual.

The necessity for widespread vaccination of the population will not, we hope, arise again, but should it so happen it would be well to exercise special caution before submitting to vaccination known cases of pulmonary tuberculosis. — Smallpox Vaccination and Pulmonary Tuberculosis, R. Y. Keers, M.D. and P. Steen, M.D., British Journal of Tuberculosis and Diseases of the Chest, July-October, 1943.

THE MEDICO-LEGAL ASPECTS OF THE TRAUMATIC NEUROSES

(Continued from Page 243)

The question of awarding or withholding compensation rests with the jury, court, or commission. The arguments of opposing counsel and the evidence offered is directed to convince the jury, court, or commission of the justice or injustice of the claimant's contention. On the other hand, the defense sometimes seeks to avoid payment of compensation regardless of the possible or probable validity of the claims presented, and the court or commission, recognizing that the action is founded on a question of material gain, is not profoundly interested in the medical testimony offered. Oftentimes the coursel has recourse to the time-honored hypothetical question that usually conceals or reveals nothing.

Although malingering must be considered in every case as a possibility, it is, I believe, less frequent than generally supposed and can with patience usually be determined. The marked susceptibility of the psycho-neurotic to auto or hetero suggestion is fully evidenced by his craving for sympathy and attention, and his willingness to discuss his feelings and disabilities at all times and under all conditions. His repertoire constantly increases as he journeys from doctor to doctor in search of health. The craving for attention and sympathy in the traumatic neuroses is supplemented in the medico-legal case by the hope of material compensation.

*Aring and Bateman have commented somewhat caustically on the compensation factor as a stimulus to the growing frequency of neuroses in World War veterans since this condition became compensable under the Veterans' Administration. Inasmuch as we have had within recent years an apparently progressive increase in the neuroses and psycho-neuroses, one may rationally postulate a parallel rise in the frequency of traumatic neuroses. As the line of demarcation between the so-called neuroses and psychoneuroses cannot be satisfactorily established, the justification for the use of the term "neuroses" seems uncertain.

Within recent years the neuroses, so-called, have

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been produced in the lower animals by repeated unpleasant stimuli, but we are not prepared to state that the lower animal is devoid of a psyche. Admittedly all neuroses, at least in the human race, have their genesis in the mental attitude of the sufferer to a recognized or unrecognized provocative stimulus, yet in some states a distinction is made that holds one as compensable while the other is not.

*Journal A. M. A. 109-14-1092.

MEN IN SERVICE

A recent newspaper release dated June 13—Aboard LST—At a Normandy Beach—Supplies are flowing almost uniterruptedly into our French beaches now and scores of ships stretch along the coast as far as one can see on this cloudy, wet morning.

Many are unloading, many others wait for the forming up of convoys back to England. I have just made my third channel crossing of the invasion and in sharp contrast to the last visit, these beaches are quiet now. Three days ago many fires raged along the beaches and the air was filled with explosions from ships bombing the enemy inland and detonations of TNT as soldiers blasted enemy tunnels in the hills . . .

These LST's (landing ships, tanks) operate with incredible informality. Officers eat the same food as the crew. The captain eats in a tiny ward room with the officers. Many men don't shave. Hurried trips with loading and unloading of men and supplies make it impossible to keep the ship clean.

It is interesting to note that two of our doctors from Kansas have already been listed as with the LST's, as the following will show.

Dr. Henry S. Dreher, of Luray, recently graduated from the University of Kansas School of Medicine, is a lieutenant in the Navy on an LST and according to the Luray item in the Kansas City Times: "Assigned as an invasion doctor on an LST that helped land men and equipment in the Normandy invasion."

ON THE HIGH SEAS—Major Emmerich Schulte, of Kansas City writes: "Close to the shores of France I received my 'Service Membership Card' for 1944 with great pleasure. It was good to see the old familiar card, to know you had not forgotten about me, and that I was still a member in good standing. Will you be so kind as to observe the change in my address, and as you can see I have joined the U. S. Navy. I had the privilege to be one of 100 doctors selected for this special job, which started about 15 days ago, and I have enjoyed it very much. As I cannot divulge any more at this time about my work, I might say that I am right in full swing of practicing my profession and the address in regard to the 'LST' number might explain to you what I am doing."

"Lt. Henry S. Blake, of Topeka, (says the Topeka Daily Capital) whose work in connection with blood banks on the West Coast has attracted very favorable attention in Army and medical circles, had lunch in the Senate Restaurant today with Senator Capper (June 11). He has been called to Washington for consultation on a nation-wide

adoption of the program he worked out on the West Coast, after returning from service with the Marines in the South Pacific,"

The Atchison Globe writes: "Dr. Ira R. Morrison, one of Atchison's physicians in service, has been promoted to major. He is on the station hospital staff at the Independence, Kansas, Army Air Base. Major Morrison went to Independence in February after having been stationed at Silman Field, Monroe, Louisiana, since August, 1942."

"Dr. and Mrs. J. H. Knapp (says the Arkansas City Traveler), have received word from their son, Lt. Col. Leslie Knapp, that he is now in West Africa. He has been overseas for more than sixteen months."

The Iola Register says: "Dr. Lyle F. Schumas, who is serving with the Army Medical Cops at Fort Snelling, Minnesota, has been promoted to major, according to word received in Iola. Major Schumas has been on active duty with the Army for about two years."

From Capt. Ward M. Cole, of Wellington, who has an APO out of Seattle, was received the following: "Received my membership card in the Society for 1944 the other day and want to thank you and the other members of the Society for carrying those of us in the Army and Navy. The Journal is just like a letter from home and is covered from cover to cover. We are especially interested in the pages concerning the doctors in the Army. The interest the Society is showing in various forms of prepayment for medical care is very encouraging. The medical profession should institute such procedure rather than wait for the politicians to take the credit. You will find most of the doctors coming home just as individualistic as ever but I think most agree that the people will want an opportunity for some type of insurance against expenses of illness. I know that the doctors of Kansas will get the job done in an adequate manner. I am in the Aleutians. The life up here isn't bad but we are rather isolated. Many of us with field units will be interested in some form of post graduate work after the war as we have become a bit rusty along some lines. Best regards to all members of the Kansas Medical Society and thanks."

Frm the Leavenworth Times we learn: "Capt. Robert H. Moore, who left Lansing to serve the colors, has returned to the States after twenty-two months in the Southwest Pacific theater. He is at Winter General Hospital in Topeka awaiting reassignment."

Dr. and Mrs. W. A. Smiley, according to the Junction City Union, have received word from their son, Capt. E. A. Smiley, attached to a medical unit in England, presumably stationed near London.

The Lawrence Journal-World carries an interesting story of one of our men in service: "Wading through icy water to a barren shore, the vanguard of American medical men arrived on one of the Aleutian Islands. In that group was Lt. Col. J. M. Mott, former physician and health officer of Lawrence, who had been chosen to head a medical crew which would establish hospitals on several of the bleak western Aleutians.

"Colonel Mott had been six months in Alaska when the



tions under fire... cuts casualty rates astonishingly. Physicians of World War II constantly face sudden death to bring modern medical miracles to fallen troops. Harrying, the war doctor's life. Weary grinds. Respites rare. Perhaps only a few moments or so now and then... time off for a welcome cigarette. A Camel, most likelyfavorite brand in the armed forces.* Camel, first choice for mellow mildness, for appealing flavor... in this war, as in the last, cigarette of fighting men.



• New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Sq., New York 17, N.Y.

1st in the Service

*With men in the Army, the Navy, the Marine Corps, and the Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)

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WAR BONDS

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assignment came and he spent twenty months in this theater, designing and supervising the building of three modern, fully equipped hospitals on land where there was absolutely nothing to do it with, and everything had to be shipped in.

"There were no docks when the first soldiers arrived at the islands. The barges came as close as they could, and the men waded ashore, carrying supplies on their backs and then walked four to seven miles inland, still carrying the load. No roads had been built yet; there were no trees or shrubs on the island which is covered with a kind of moss and gives way after the second or third man in a row has trod on it, revealing thick mud. With them the medical officers carried eight cases of surgical equipment, enough for eight major operations, wrapped in water re-

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FOR SALE OR LEASE—Kansas physician's and surgeon's practice on account of death; established 40 years; good steady income; equipment included; excellent opportunity. Write Journal of the Kansas Medical Society—C-O-17.

FOR SALE—Practice of deceased physician. Complete E. E. N. & T. instruments and equipment. Mercury quartz and radiant lamps, Victor vario frequency, Wappler wall plate, complete deep therapy x-ray installation, including 140 Kv. shock proof tube and stand, 200 Kv. tube and table. Radiological journals and medical books. Write the Journal C-O-19.

FOR SALE—General practitioner's office equipment, including some hospital furniture. Two large roll top desks with chairs; 1 filing cabinet, universalmode, Thompson-plaster electric cabinet, a two unit electric sterilizer with white enamel cabinet, 2 large instrument cabinets, 2 large laboratory tables with marble tops, 38 units of sectional bookcases, library of 260 medical books, a Bausch & Lomb microscope, 4 non-crank type hospital beds and stands, two examining tables, some hospital linens, surgical instruments, including some very good proctology instruments, a hand suppository machine, a centrifuge and bound copies of the Journal of the American Medical Association from 1906 to 1924. Write C-O-16.

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pellant coverings, and these had to last for two months before they received more. . . .

"Seven days after the landing, a soldier with an almost ruptured appendix was operated upon in a tent, in a howling gale. The operating table was a litter upon two soap boxes; because the room was heated with a coal stove, the patient's head was left outside the tent so ether could be given away from the stove, and a wet sheet was hung in the tent doorway. The operating doctor removed his shirt rolled up the sleeves of his woolen underwear, and operated, while standing ankle-deep in mud. The soldier was soon back on duty. . . .

"The first four days on the islands the men had no heat. The coal was in the hold of the ship and the last thing to be taken out. . . .

"The coal, like everything else, was carried ashore in sacks on the backs of men. Now Diesel fuel is used on the islands. Water had to be carried from streams uphill to the camp, in buckets, put in a Lister bag and chlorinated before it could be used. . . .

"On one island, Colonel Mott's staff of doctors and men, without the aid of construction workers, put up ninety-two buildings in ninety-four days. . . .

"Colonel Mott said when he left, three ultra-modern hospitals had been completed, with insulated walls, electric outlets beside each bed, covered walks between buildings, and the latest in x-ray and surgery equipment. . . .

"He had glowing praise for the work of the Red Cross in the Alaskan theater. . . .

"The sick and wounded there are now getting the same care they would here in the United States in the best hospital in the land."

Lt. M. D. McComas, of Courtland, the son of Dr. M. D. McComas, is stationed at Billings General Hospital, Ft. Benjamin Harrison, Indiana.

The Peabody Gazette has the following to say: "Dr. E. H. Johnson visited several hours Friday with Capt. H. O. Williams. Capt. Williams was a former partner of Dr. Johnson's and was being transferred from California, where he was stationed with the medical department of the U. S. Army, to an alert station on the east coast.

Ted Varner, former attorney for the Kansas State Board of Medical Registration and Examination is a sergeant with an APO out of San Francisco. We believe Sgt. Varner is with headquarters and is doing, so Dr. Hassig tells us, similar work to that previously done in Independence where he lived.

Lt. Col. Dale C. McCarty, of Lawrence, has been transferred from Harahan, Louisiana, and has given us an APO address out of New York.

Capt. Max E. Kaiser, of Ottawa, has been transferred from Camp Anza, California, to Torrence, California.

Capt. Charles Woodhouse, of Cheney, is now in New Caledonia. Mrs. Woodhouse has written requesting that the Journal be sent to his new address.

Major Robert L. Lee, of Kansas City, writes from England: "Please send my Journal to the address listed below and many thanks."

Capt. Joseph W. Manley, of Kansas City, writes to change his Journal address to an APO out of New York.

From a Cleveland, Ohio, newspaper the following story is of interest to Kansas men due to the fact that Dr. E. H. Hashinger was with the University of Kansas School of Medicine unit overseas: "The Allied invasion of France is of peculiarly poignant interest to Lt. Col. Edward H. Hashinger, of Kansas City, now chief of the medical service



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JULY, 1944 255

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^{*}Commenting editorially on the work of Mills and Cottingham (J. Immunol. 47:503 [Dec.] 1943), THE JOURNAL states: "They found that after five and one-half weeks maintenance at 68 F. rats showed a maximum phagocytic activity on diets containing 18 per cent of protein. There was a definite decrease in phagocytic activity with an increase or decrease from this level. In rats maintained at 90+F. the phagocytic optimum diet was 36 per cent of protein. Thus adequate protein intake would seem to be fully as important as adequate vitamin intake to maintain optimal phagocytic activity (resistance to microbic infections). The immunologic optimum protein intake is higher in the tropics than in temperate climates. . . . This demonstration of important variations in phagocytic functions is a pioneer contribution to basic immunologic theory and may have wide clinical implications." (J.A.M.A. 124:1203 [April 22] 1944.)

of the Army's Crile General Hospital here. Colonel Hashinger organized the evacuation hospital at the University of Kansas Hospital in Kansas City and went to Tunisia with it by way of England in 1942.

"When the unit was leaving England that year, it took with it a supply of sulfadiazine pills at Colonel Hashinger's suggestion, as there had been pneumonia among the men and women of the outfit. The medical officers carried the pills in their personal luggage on their backs, in case they should be needed aboard ship. It was fortunate they did, for the hospital unit, landed in Oran, Algeria, was separated from its supplies several days and marched thirteen miles inland.

"Lt. Col. Mahlon Delp, now on duty at Crile hospital here, carried 1,000 sulfadiazine pills in a sock in his musette bag, and he still insists he felt the extra weight of each pill every mile of the thirteen. When the unit took over the Oran City hospital, meagerly supplied, an officer was found unconscious from meningitis. The sulfadiazine pulled him through.

"Colonel Hashinger remembers well the shivering cold days when the hospital unit was camped on the plateau near Tebessa. It was living on C rations and bartering extra clothes to the Arabs for eggs and chickens.

"In the city of Tunis, in the beautiful churchyard of St. George's Anglican church, Colonel Hashinger came across the tomb of John Howard Payne, author of 'Home Sweet Home.' Payne died in Tunis while serving as American consul there in 1852. Looking around him at the desolation, destruction and decay which were Tunis, the Kansas City doctor thought how different things must have been when Payne wrote 'mid pleasures and palaces.' The palaces now were crumbling fast and the pleasures not

observable. Colonel Hashinger, leaning against Payne's monument, agreed eagerly that there was no place like home."

Capt. Frank A. Rieke, of Shawnee, requests a change in his address to an APO out of New York. Captain Rieke has been stationed at Camp Campbell, Kentucky.

Lt. A. E. Rueb, of Salina, has been transferred from William Beaumont Hospital at El Paso, Texas, and now has an APO address out of Seattle, Washington.

Lt. Lucien A. Watkins, of Leavenworth, has been transferred from Lowry Field, Denver, Colorado, to the Fitz-simmons General Hospital, in Denver.

Capt. Charles T. Frey, of Wichita, has been transferred from a Station Hospital in Kansas City, Missouri, to Recruiting Center at Jefferson Barracks, Missouri.

Major Garth S. Ortman, of Kansas City, has been transferred from Ft. Sam Houston, San Antonio, Texas, to Camp Joseph T. Robinson, Arkansas.

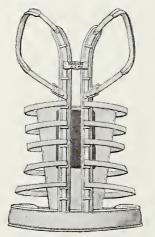
Dr. Letteer Lewis, of McPherson, is now a captain in the Medical Corps with a bomber squadron in the Pacific.

Major Frederick W. Matassarin, of Wichita, recently transferred to Memphis, Tennessee, has written to give us his APO address out of New York.

Major W. M. Brewer, of Hays, stationed at Camp Gruber, Oklahoma, has been transferred to Topeka.

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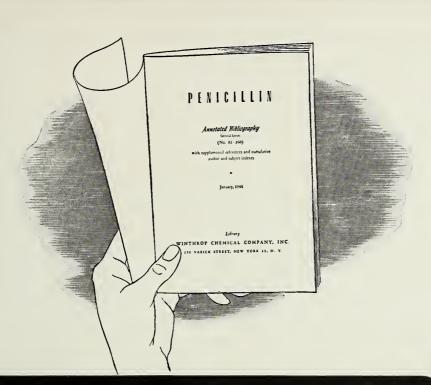


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NEWS NOTES

A. M. A. MEETING

A total of 7,284 attended the Ninety-fourth Annual Session of the American Medical Association in Chicago on June 12-16, 1944. The meetings of the next three sessions will be held as follows: New York in 1945; San Francisco in 1946; and Atlantic City in 1947.

The new officers of the Association elected for 1944-1945 are as follows: Dr. Herman L. Kretschmer, of Chicago, president; Dr. Roger I. Lee, of Boston, president-elect; Dr. Stanley J. Seeger, of Texarkana, Texas, vice-president; Dr. Olin West, of Chicago, secretary; Dr. J. J. Moore, of Chicago, treasurer; Dr. H. H. Shoulders, of Nashville, Tennessee, speaker of the House of Delegates; Dr. R. W. Fouts, of Omaha, Nebraska, vice-speaker of the House of Delegates; Dr. Louis H. Bauer, of Hempstead, New York and Dr. E. L. Henderson, of Louisville, Kentucky, to the Board of Trustees (term to expire in 1949); Dr. Edward R. Cunniffe, of New York, Judicial Council (term to expire 1949); Dr. Charles Gordon Heyd, of New York, Council on Medical Education and Hospitals (term to expire 1951); Dr. Charles H. Phifer, of Chicago, Council on Scientific Assembly (term to expire 1949); Dr. A. W. Adson, of Rochester, Minnesota, and Dr. W. S. Leathers, of Nashville, Tennessee, to the Council on Medical Service and Public Relations (term to expire 1945); others to the same Council were as follows: Dr. E. J. McCormick, of Toledo, Ohio; and Dr. Thomas A. McGoldrick, of Brooklyn, New York (term to expire 1946); Dr. John H. Fitzgibbon, of Portland, Oregon, and Dr. James R. Mc-Vay, of Kansas City, Missouri (term to expire 1947).

Dr. George Dock, internist and pathologist of Los Angeles, was awarded the Distinguished Service Medal at the House of Delegates meeting on June 12. Dr. Dock is noted for his work on the pathology of malaria and dysentery, protozoan diseases of the blood, pernicious anemia, the ductless glands and hookworm. He was born at Hopewell, Pennsylvania, in 1860 and received his degree from the University of Pennsylvania School of Medicine, Philadelphia. He was assistant professor of pathology of the University of Pennsylvania School of Medicine in 1887-88, professor of pathology of Texas Medical College, Galveston, 1888-91, professor of the theory and practice of medicine and clinical medicine at the University of Michigan Medical School, Ann Arbor, 1891-08, professor of medicine at Washington University School of Medicine, St. Louis, 1910-22, and was made honorary professor of medicine of the University of Southern California School of Medicine, Los Angeles. He was Vice-President of the international medical congress at Moscow in 1897 and at London in 1913. He is a member of the Association of American Physicians, of which he was president in 1916-17 and is the co-author of a book on hookworm diseases and the author of numerous scientific articles in medical journals and textbooks,

The War Session was one of the high-lights of the meeting, another was the introduction of many famous celebrities including: Lt. Gen. Robert Kho-Sheng Lim, Director of Planning of the Medical Department of the Chinese Army; Dr. Benvenuto R. Dino, personal physician to the president of the Philippines; and a great many representatives of the Medical Corps of the Army and Navy. The registration listed medical men from: Iran, Mexico,



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Canada, France, London, Peru, Puerto Rico, Brazil, Cuba, British Columbia, Bolivia, Argentina, Guatemala, England, Prince George, British Columbia, Portugal, South Africa, Chile, Hawaii, Central America and Alaska.

The most outstanding action of the House of Delegates was the following: Recommendation that the Children's Bureau be removed from the Department of Labor and placed under the Department of Public Health (the E. M. I. C. program is under the supervision of the Children's Bureau and enforced, at least in Kansas by the State Board of Health). It was also recommended that an effort be made to create a new department of health in the Cabinet of the President of the United States, with a Secretary of Health as a member, allocating all health activities, health education, the work of the Children's Bureau, the United States Public Health Service, and all matters pertaining to health to this department. Great alarm was expressed over the fact that no pre-medical students would be deferred after July 1. Dr. Lahey has been working on this but reported no action and expressed the seriousness of the situation if action was not taken at once.

The following Kansas members were in attendance at the meeting: Lewis G. Allen, Kansas City; Graham Asher, Kansas City; Arthur L. Ashmore, Wichita; L. F. Barney, Kansas City; M. L. Bishoff, Topeka; J. J. Brenneman, Moundridge; A. J. Brier, Topeka; T. J. Brown, Hoisington; W. L. Butler, Stafford; Leo K. Crumpacker, Wichita; E. S. Edgerton, Wichita; Frank Foncannon, Emporia; John D. Green, McPherson; Hartin Hagan, Wichita; J. F. Hassig, Kansas City; C. C. Hawke, Winfield; C. Alexander Hellwig, Wichita; C. E. Henneberger, Atwood; H. L. Hiebert, Topeka; John G. Hoffer, Wichita; O. G. Hutchin-

son, Marysville; H. F. Janzen, Hillsboro; J. H. Jennett, Kansas City; E. L. Kalbfleish, Newton; J. L. Lattimore, Topeka; Dwight Lawson, Topeka; Frank Lenski, Iola; Eugene O. Liddy, Lawrence; Paul S. Loewen, Wichita; Paul H. Lorhan, Kansas City; F. L. Loveland, Topeka; L. R. McGill, Hoisington; C. D. McKeown, Wichita; H. C. Markham, Parsons; Karl Menninger, Topeka; W. C. Menninger, Topeka (Washington, D. C.); E. S. Miller, Kansas City; S. Murdock, Sabetha; Barrett A. Nelson, Manhattan; P. J. O'Connell, Kansas City; A. A. Olson, Wichita; W. A. Parrish, Pittsburg; Don Carlos Peete, Kansas City; J. H. A. Peck, St. Francis; John W. Randell, Marysville; H. L. Regier, Kansas City; W. E. Regier, Whitewater; R. W. Robb, Osawatomie; C. Rucker, Sabetha; Wm. B. Scott, Topeka; R. C. Smith, Marion; Roy K. Smith, Norton; C. F. Taylor, Norton; L. M. Tomlinson, Harveyville; Claude C. Tucker, Wichita; C. C. Underwood, Lyon; C. J. Weber, Kansas City; George A. Westfall, Halstead; D. E. Woods, Osawatomie; F. E. Wrightman, Sabetha; and Edwin T. Wulff, Atchison.

Several men in service stationed in Kansas also attended the meeting from Kansas. These men, however, are not Kansas members: Harry Alban, of Salina, formerly living in California; Capt. F. T. Cultrone, of Salina, formerly of Philadelphia; Major James E. Dollard, of Liberal, formerly of Madison, Wisconsin; and Lt. Comdr. Norman L. Yood, of Olathe, formerly of Washington, D. C.

T. B. ASSOCIATION HOLDS ELECTION

The thirty-third annual meeting of the Kansas Tuberculosis and Health Association was held in Topeka on June 6-8 with some of the sessions held jointly with the Kansas Public Health Association. Dr. C. E. Coburn, of Kansas

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MEDICINE—Two Weeks Personal Course in Electrocardiography and Heart Disease starts August 7. Two Weeks Course Internal Medicine starts October 16.

GYNECOLOGY—Two Weeks Intensive Course starting October 2. One Month Personal Course starts August 7. One Week Course Vaginal Approach to Pelvic Surgery starts October 23.

OBSTETRICS—Two Weeks Intensive Course starts October 16.

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City, was elected as president of the organization; Dr. F. A. Trump, of Ottawa, as the new vice-president; and Dr. C. H. Lerrigo, of Topeka, was re-elected as the executive secretary. Dr. Lerrigo has held the office of executive secretary since 1923, and was a volunteer worker for the organization preceeding that time.

VICE-PRESIDENT OF KANSAS PUBLIC HEALTH ASSOCIATION

Dr. J. E. Wolfe, of Wichita, was elected as vice-president of the Kansas Public Health Association at its annual meeting held in Topeka on June 6-8, 1944. Dr. Wolfe is the city health officer of Wichita and the author of a monthly health column in the Sedgwick County Medical Bulletin.

Dr. D. Carr, retiring president of the organization, was elected as a member of the executive committee. Other high-lights of the meeting were talks by Dr. J. L. Lattimore and Dr. C. C. Applewhite, medical director of the Seventh District of the United States Public Health Service, of Kansas City. Dr. Applewhite's talk will be published in an issue of the Journal in the near future.

GOLDEN BELT MEETING

The quarterly meeting of the Golden Belt Medical Society was held in Manhattan on July 6, with the Riley County Medical Society acting as hosts. Officers of the Society are Dr. E. M. Sutton, of Salina, president and Dr. George E. Brethour, of Dwight, secretary.

The following speakers appeared on the program: Dr. Robert Pfeutze, of Topeka, spoke on "The Blue Baby"; Capt. Frank A. Christenson, of the Station Hospital of the

Topeka Army Air Base, discussed "Penicillin Therapy in Primary Untreated Gonorrhea in the Male"; Capt. Irwin Stein, of the Winter General Hospital of Topeka, discussed "Penicillin, its use in Sulfa-Resistant Gonorrhea, and its other use in conditions which are met in an Army General Hospital"; and Capt. Joseph W. Gooch, of the Station Hospital of the Topeka Army Air Base, spoke on "Primary Atypical Pneumonia, With a Report of Cases."

MEMBERS OF BOARD OF HEALTH RE-APPOINTED

Governor Andrew F. Schoeppel recently announced that the following members of the Kansas State Board of Health had been re-appointed: Dr. J. F. Gsell, of Wichita; Dr. R. T. Nichols, of Hiawatha, and Dr. Hugh A. Hope, of Hunter.

The appointments were made on April 15, 1944 and will not expire until March, 1947. Other members of the Board are as follows: Dr. Geo. I. Thacher, of Waterville; Dr. H. L. Aldrich, of Caney; Dr. J. L. Lattimore, of Topeka; Dr. G. A. Leslie, of McDonald; Dr. F. L. Loveland, of Topeka; Dr. Clyde D. Blake, of Hays, and Mr. Reginald D. Glandon, of Kansas City, attorney member.

HEALTH RADIO SERIES

A radio health program has been instituted over station KFKU, in Lawrence (station WREN) each Monday night at 9:45 o'clock. The new series "Health for Happiness" is sponsored by the Kansas State Board of Health and endorsed by the following organizations: the Kansas Tuberculosis and Health Association, the Kansas State Board of Agriculture, the Kansas State Teachers Associa-

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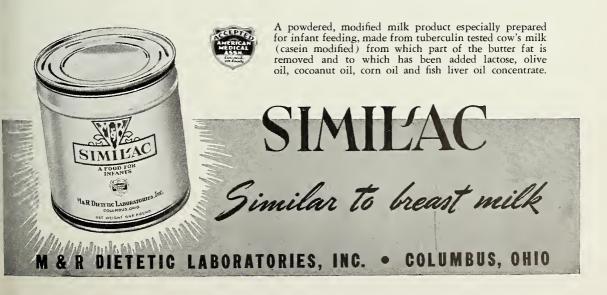
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JULY, 1944 263



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tion, the State Labor Department, the State Department of Social Welfare of Kansas, the Kansas Children's Home and Service League, the Kansas State Nurses' Association and the Kansas Medical Society.

The first three programs were under the supervision of Dr. Leon R. Kramer, Director of the Division of Dental Hygiene, Mr. Evan Wright, of the Food and Drug Division and Miss Minnie Fleming, State Registrar and Director of the Division of Vital Statistics.

The remainder of the radio program is as follows:

July 10-"Safe Well Water," Mr. Paul Haney, Director of the Division of Sanitation.

July 17-"What Can We Do About Cancer?" Dr. F. C. Beelman, Executive Officer and Secretary, of the Kansas State Board of Health.

July 24—"Saboteurs of Health," Dr. R. M. Sorensen, Director of the Division of Venereal Disease Control.

July 31—"Diphtheria and Smallpox Must Go," Dr. C. H. Kinnaman, Director of Epidemiology.

August 7-"Tuberculosis Can Be Conquered," Dr. H. L. Hiebert, Director of the Division of Tuberculosis Con-

August 14-"The Light of Life," Miss Mae Hare, Coordinator of Health Education.

DEATH NOTICES

Dr. Herman Elwyn Pearse, 85 years of age, died on June 10 at his home in Bonner Springs. He was born in Bloomington, Ill., in 1859, attended the University of Kansas and was graduated from the St. Louis College of Physicians and Surgeons in 1888. He was one of the founders of the old Kansas City Medical College. In 1934 he retired from active practice but was an honorary member of the Leavenworth County Medical Society.

Dr. Fred H. Rhoades, 64 years of age, died on June 20. His home was in Hanover. He was born on July 22, 1879, at Lytle, Ohio. Graduated from the University of Kansas School of Medicine in 1905 he was an active member of the Washington County Medical Society. He had practiced first at Altoona, moving to New Albany, to Mulberry and then in 1915 to Hanover where he had practiced since that time.

Dr. Foster L. Dennis, 49 years of age, died on June 26 at his home in Dodge City. Dr. Dennis was preparing to leave for Chicago to report for duty as chief of all surgical service in a medical corps hospital and had received the commission of major in the Medical Corps. He had



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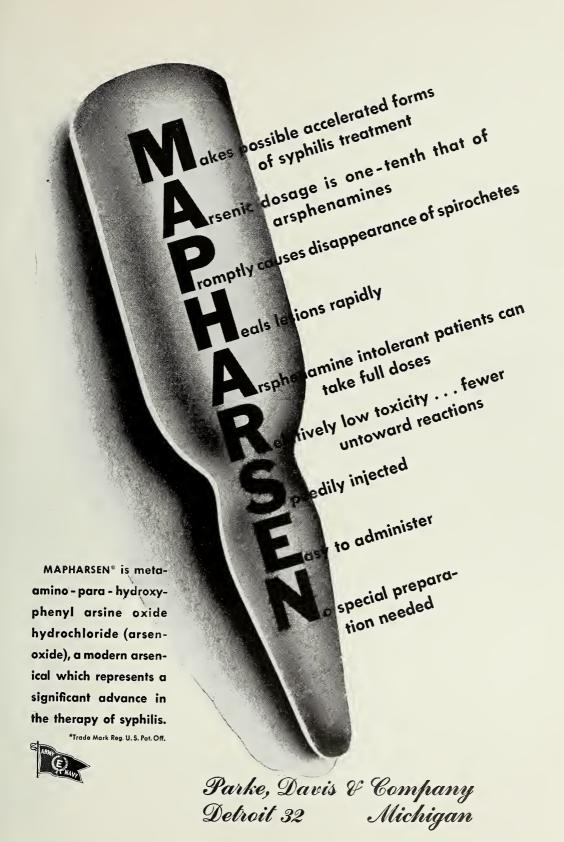
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formerly been stationed at Walter Reed General Hospital in Washington, D. C., was formerly attached to the 22nd General Hospital which is now overseas and becoming ill previous to embarcation had been placed in limited service. He was born at Westmoreland, on November 12, 1895, was graduated from the University of Kansas and from Jefferson Medical College, Philadelphia, Pa., in 1921. He was a member of the Medical Corps in World War I and was an active member o the Ford County Medical Society.

Dr. Myron L. White, 72 years of age, died on June 4 at his home in Coffeyville. He was graduated from the Durham Medical College, of Chicago, in 1901 and was a member of the Montgomery County Medical Society. He was a veteran of World War I.

Capt. Ralph Milton Wyatt, 39 years of age, of Hiawatha, was killed in a plane crash at Aldershot, England, on June 8. He was graduated from the University of Kansas School of Medicine in 1933 and was a member of the Brown County Medical Society, at the time of his enlistment in the Army Medical Corps. He was a flight surgeon and had been in England since February, 1944.

TO EXCHANGE MEDICAL SERVICE

A reciprocal agreement for medical treatment of members of the Canadian and United States armed forces has been completed by the two governments, the War Department announced recently. Under the agreement, United States service men in Canada who cannot obtain medical or dental treatment from United States sources will receive free treatment from the Canadian medical and dental services. Similar treatment will be accorded Canadians here.

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AUXILIARY

PRESIDENT'S MESSAGE

Your president recently returned from the National Convention of the Auxiliary which was held in Chicago June 12-15. I wish it had been possible for all members to have been present, meet the National and state officers and delegates from all parts of the United States. We met with them formally at the convention meetings and informally in the hotel lobby. We exchanged ideas with other state officers and discovered that the National officers were individuals without a halo and were physicians' wives who had worked a little harder with Auxiliary objectives, thus reaching the top.

Since all of our 400 members couldn't come to Chicago, will you attend the meetings using my eyes and ears? Kansas was represented by your president and your four delegates Mrs. Hugh H. Hope, president elect, Hunter; Mrs. W. Y. Herrick, Wakeeney; Mrs. H. L. Regier, and Mrs. L. B. Spake, Kansas City. Other Kansas members attending the meetings were Mrs. W. L. Butler, Stafford; Mrs. J. Henshell, Osborne; Mrs. T. J. Brown, Hoisington, and Mrs. H. L. Hiebert, Topeka. All Auxiliary members may attend the meetings and social functions but only elected delegates or their alternates may vote. Each state is entitled to one delegate for each one hundred members so all of our delegates were present.

The first day the preconvention meeting was held, attended by National officers and state presidents. Fate was with me, as I boarded the same elevator with Mrs. Eben J. Carey, National President, our badges identified us so she introduced me to the assembly. General business to be acted upon by the general convention was discussed, the new Constitution and By Laws being the chief subject.

The second day 520 National Board members, delegates, alternates, members and guests were reported by the credentials chairman. Mrs. Eben J. Carey, president presided and a very capable chairman she proved to be. Dr. Bundeson of Chicago extended greetings from the Mayor. In making an address he said he had learned three things-"be brief, be sincere, and be seated." In closing he gave a quotation on "Age-a quality of the mind." The president elect, Mrs. David W. Thomas, was presented. The highlights of the National officers reports were: In 1944, a membership of 24,356, a loss of only 184 members mostly due to war service; 133 members died, Kansas was one of the few states reporting no deaths; 41 states and the District of Columbia are organized consisting of 612 Auxiliaries; thirty state presidents were present; only 1,313 members are Bulletin subscribers which to me represents lack of stressing its importance by state presidents and in turn county presidents who have close contact with the membership. The Bulletin is our official "text-book" and if we wish to be informed, we must read it. (See Mrs. Beelman's article in the June Kansas Medical Journal.)

The discussion of the Constitution and By Laws used most of the time both days of the general assembly. The removal of the state presidents and national chairmen from the National Board and placing them in an assembly meeting of their own together with the state president elects seemed to cause the most dissention. The discussion brought forth a real course in parliamentary procedure and the parliamentarian was a marvelous woman. The new plan was adopted and personally I feel it will be of great assistance to the presidents and president elects. The luncheon was in honor of Mrs. Eben J. Carey, retiring president. Vice Admiral Ross J. McIntire, Surgeon General of the United States Navy, was the speaker-his subject being "Woman and the War." In the evening we attended the opening meeting of the A. M. A.

The third day, the Constitution and By Laws discussion continued leaving no time for the reports of the state presidents, which will be published in the Bulletin. New officers were elected and installed. The president elect, Mrs. Jesse D. Hamer, is a young woman from Phoenix, Arizona. The past presidents were honored at the luncheon this day and guest speakers were Dr. Herman R. Kretschmer, A. M. A. president; Dr. James E. Paullen, A. M. A. past president; Dr. Morris Fishbien, editor of Hygeia and A. M. A. Journal. Dr. Kretschmer urged our support and promotion of Hygeia especially to young mothers and to show his sincerity he presented the Auxiliary a plaque in memory of his wife on which the winners of the Hygeia contest will be inscribed each year. Kansas can be listed on that plaque next year if you say so. Sample copies of Hygeia will be mailed to any of your friends if you send their names to the state Hygeia chairman, Mrs. John A. Billingsley, 2024 Washington Boulevard, Kansas City, Kansas. In the evening we visited the Museum of Science and Industry and had dinner there. Later we attended the War Meeting of the A. M. A. with medical speakers from the United States, England, Russia, Canada, and China.

The last day's meeting was for National Board, presidents and president elects. The chairmen outlined their plans for the year which will be published in the next issue of the National Bulletin,

Kansas Auxiliaries compare very favorably with all other states but if every physician's wife will (1) be a member (2) subscribe to the National Bulletin (3) place two or more Hygeia subscriptions, we can be far ahead of all other states.

At our state convention next May we may have a very distinguished assembly-Mrs. Thomas, national president, Mrs. Carey, national past president, and Mrs. Hamer, national president elect. If we plan well now we can have a real report to present to them. Our success rests not with the officers but with each individual physician's wife.

Sincerely yours, Mrs. Leo J. Schaefer.

ORGANIZATION

Richard Steele once said, "The noblest motive is the public good." The wife of every physician is anxious to help win the war, whether her husband has joined the armed forces or has been left to care for the civilian population. The public looks to the medical profession for the control of disease and the doctor's wife is expected to know the health problems of her community. It takes interest, study and hard work to get this information. The Woman's Auxiliary stands ready to help the doctor's wife gain authentic information through its chairmen and Bulletin.

As state organization chairman, I would like to ask every county president to invite doctors' wives from adjoining unorganized counties to visit their meetings and suggest that they become members-at-large. Through these members-at-large it may be possible to organize their county with them as a neucleus. Any wife, mother, or widow of a physician who is a member of the Kansas Medical Society is eligible.

Everyone needs the Auxiliary and the Auxiliary needs everyone.--Mrs. E. E. Tippin, Chairman of Organization.

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THINKING AHEAD IN PUBLIC HEALTH

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Kansas City, Missouri

To obtain a clear-cut picture of what the future public health program will be like, it is deemed fitting to review past public health activities to determine which of those items have been successful in achieving worth-while results, and which have been nonproductive. In reviewing past performances and daydreaming about future public health programs, the modern public health worker must not take his eye off of the program which is now being executed. It is also deemed expedient to recount briefly some of the basic concepts of public health organization and administration.

It is now generally recognized that the state health department is definitely responsible for the task of safeguarding the health of the people within that state. Authority for the administration of the public health program reposes only in the state or local health officer. The authority exercised by others in either the state or local health departments must be delegated to them either by the state health officer or the local health officer. The health department which discharges fully its responsibility must have at all times the enthusiastic support of the people served. Since the executive officers of the state and local health departments are members of the medical profession, organized medicine should always give enthusiastic support to the public health program.

If it is the responsibility of the state health department to safeguard the health of the people, why then should the U. S. Public Health Service be interested in local health service? There are two reasons for this. First, national defense is a definite responsibility of the Federal government. Safeguarding the health of the civilian population in time of war is regarded as a definite and integral part of a national defense program. Hence, the Federal gov-

ernment, through the U. S. Public Health Service, is discharging its legal responsibility in this field. Second, by an Act of Congress, the U.S. Public Health Service is charged with the responsibility of preventing the interstate spread of disease. Manifestly, it would be folly for the Public Health Service to throw a cordon of officers around each state for the purpose of preventing the spread of diseases from one state to another. For more than twenty-five years, the Public Health Service, in cooperation with the various state health departments, has endeavored to determine how best to prevent the interstate spread of diseases. After years of trial and experimentation, it has been definitely determined that the best method lies in controlling a disease at its source. To achieve this result, local public health machinery is needed. Through years of cooperative effort it has been found that the agency par excellence for achieving this result is the local health department, manned by well-trained and experienced personnel who devote their entire time to the task of preventing disease and to the promotion of sound health programs. As a result of the cooperative Federal-state health services in many of the states, Title VI of the Social Security Act was passed in 1935, and funds thereunder were made available for cooperative health work in 1936. At long last, the Public Health Service is in a position to pay the local health department for rendering invaluable service in the matter of preventing the interstate spread of disease. As a result of the passage of the Social Security Act, there has been a phenomenal expansion in certain areas of the United States of full-time local health services. In 1942 the people of 1,828 out of 3,070 counties were enjoying the benefits of some type of full-time local health service. The need for further expansion becomes acutely apparent when the broad public health needs of this country are taken into consideration.

Improvements in the field of public health during the past quarter of a century have been little short of miraculous. These results have been accomplished with rather poorly organized and improperly integrated public health services. As a result of organized community action, typhoid fever, iliocolitis,

^{*} Medical Director, U. S. Public Health Service.

diphtheria and, to a great extent, whooping cough have, for all practical purposes, been eliminated as a major public health problem. Great progress has been made by organized effort toward reducing the morbidity and mortality rates from tuberculosis. With recently developed methods of case-finding, and expected improvement in treatment facilities and techniques, this disease should within the not distant future cease to be a major health problem. Pneumonia, the captain of the men of death, bids fair to yield its death-dealing hold on the human family as a result of the march of science, with its chemical weapons of action. Recent discoveries of methods of treatment for the venereal diseases offer a very favorable prognosis for early control of these diseases. Recent statistics released by the Bureau of the Census show that the general death rate for the United States for the year 1942 reached a new low of 10.3, and that the infant and maternal death rates for the same year were the lowest in history. All these results have been accomplished by organized community effort, fostered and promoted by public health agencies, both official and unofficial, and participated in very actively by members of the organized medical and allied professions. It may be stated parenthetically that any public health program, to be eminently successful, must be actively supported by the medical and allied professions.

Lest this brief review of the success which has been achieved during the past few years should generate a feeling of self-satisfaction and complacency, attention is here directed to some problems of public health which clamor for solution. The physical unfitness of the men called to active duty under the Selective Service Act of World War II should cause all of us who are interested in the advancement of medical science a definite sense of humiliation. Forty-six percent of the first two million men examined under this draft were labeled unfit for military service. To be sure, the physical standards in the beginning were rather high. Yet, with the lowering of the standards, more than one-third of the men between twenty and thirty-eight were declared physically unfit. A detailed study of the causes of rejection reveals the fact that a large percentage of these rejectees would have been physically fit if they had availed themselves of the scientific services which the medical profession was capable of supplying. For a number of years the medical profession has been warned that a large proportion of the people did not get proper medical care. For years it has been known that eyes, teeth, venereal diseases, and mental hygiene were subject to serious neglect. Propaganda from high places has lulled the medical profession to sleep with the assurance that the American people are the healthiest people on earth and that medical service of the best grade in the world is available to them. The revelation of the draft indicates how adroit the deception has been. It is evident that there has been a terrific lag between scientific medical discoveries and the practical application of those discoveries to the people at large. Several factors may be responsible for this lag.

In the first place, it may be due to the fact that the general public has not been thoroughly informed relative to the advantages to be derived from the practical application of these discoveries. It is the function of any well-organized health department to acquaint the general public with the scientific public health facts in such a manner that practical application will be made of the information thus obtained. The personnel of the health department should function as a liaison agent between the general public and the medical and allied professions. The state and local health departments may be responsible for a considerable amount of this lag.

Another factor which may have contributed to this lag may be the failure of some members of the medical profession to keep abreast of the serious need and to supply the general public with the services required. The rapid growth of medical knowledge and the general competence of the profession has made it natural for the people to look to physicians for advice with respect to the prevention and cure of their ills. This same rapid accumulation of medical knowledge also makes it impossible for one physician to master the entire field. For this reason, the practice of group medicine, where the patient may have the advantage of several types of services, should become increasingly popular with the general public.

Still another factor, and probably one of the chief factors in the causation of this lag, is the lack of funds with which to pay for reasonably adequate service. The committee on the cost of medical care, in a survey in 1929, the peak year of prosperity, found that 59.5 per cent of the families had an annual income below \$2,000. The National Health Survey, made in 1936, has shown that in the United States there are forty million people in families having a total annual income of less than \$800. Among this group it was found that almost eight million cases of illness were receiving inadequate care, and that approximately two million of these most serious illnesses received no medical care at all. From these family income figures, it can readily be seen that in approximately one-third of the population one case of catastrophic illness would be sufficient to throw a member of this class into the relief group. It is manifestly impossible for the medical

profession to assume the responsibility for caring for this terrific illness load without any thought of remuneration. How definitely to solve this problem in an American way is a task which confronts the medical profession as well as the statesmen. The mere fact that medical societies are now discussing and experimenting with various plans for delivering medical care to those in the low income group indicates that the leaders in that profession are giving serious consideration to this problem and augers well for its final satisfactory solution.

In promoting the establishment of reasonably adequate full-time local health departments, either county or district, one often meets with the rather hackneyed statement in certain areas of the United States, "This is the entering wedge to state medicine.' This statement is still being made, in spite of. the fact that the American Medical Association has gone on record in favor of this procedure. On June 10, 1942, the House of Delegates of the American Medical Association unanimously voted its approval of the extension of this type of service. There was published in the Journal of the American Medical Association, April 3, 1943, a lengthy editorial advocating enthusiastically the expansion of full-time local health services throughout the length and breadth of the United States. The closing paragraph of this editorial reads as follows: "The career of public health as a specialty of medicine requiring graduate university training and practical experience is so far accepted as a part of the pattern of preventive medicine that the survival of the part-time general practitioner as the local administrator of a health department cannot be encouraged by the medical profession or be recommended to the taxpayer as the best his money can buy in public health.'

Attention is here called to the fact that in two states (Alabama and South Carolina) the State Medical Association has been designated by law as a State Board of Health. It is of interest to note that at the outbreak of the present war the people of all the counties in both states were enjoying the benefits of whole-time local health service. The medical associations in both states have led constructively in the field of public health, and the people have gladly followed that leadership. Should state medicine develop in the future, it is felt that organized medicine in those states will be in a position to assume direct leadership in that field, since it has already demonstrated its ability to lead constructively in one important field. In such an event, what will be the status of organized medicine in those states where this ability for constructive leadership has not been tried and demonstrated?

It is seriously recommended that this association take definite steps now, in cooperation with the medical and allied professions, to develop plans of organization for the complete coverage, as soon as competent personnel can be obtained, of this state, with full-time cooperative local health services. What others have done, you can do also, if the urge is sufficiently strong. It is a project particularly worthy of your organization, and merits prompt and serious consideration at this time.

In perfecting such a state-wide organization, certain basic principles should be borne in mind:

- 1) Local health departments should be limited to a population group of 25,000 or more, preferably 50,000. In this state, to obtain this population, it will be necessary in many instances to combine two or more counties into a district.
- 2) Local financial participation must be obtained. Pride of ownership must be constantly stressed for the successful operation of local health service on the basis of that eternal verity, "Where your treasure is, there will your heart be also."
- 3) A sane and constructive public health program must be designed and proposed. The main items of such a program should embrace public health education, control of communicable diseases, maternal, infant and school health services, mental and adult hygiene, and a broad program of environmental sanitation. Such a program should strive to accomplish the following results:
- a) See that every home in the area over which the department has supervision has a safe water supply, a safe method of excreta disposal, and is effectively screened against flies and mosquitoes.
- b) Insure a safe public water and milk supply and see that the public food vending establishments comply with accepted practices of sanitary procedure.
- c) So conduct the maternal and infant health program that every expectant mother has adequate prenatal, obstetric and post-natal care; that every infant has modern scientific supervision through the first year of its life; and that every preschool child has that type of supervision which will insure that, by the time school age is reached, he is free of all correctable physical defects and is protected against those diseases for which an immunization agent is available. As this is done, school health work will assume a minor role in the general health program.
- d) Arrange for participation in the program designed to rehabilitate returning soldiers.
- e) Give serious consideration to the development of a constructive mental hygiene program, with a view of reducing the incidence of neuro-psychiatric conditions.

f) Provide stimulation for a program designed to ascertain what can be done to reduce the mortality rates from the degenerative diseases.

To execute such a program, it becomes at once evident that full-time, well-trained personnel will be required. Can such a program be executed? Recently, there came to the desk of the writer a report of a county health department in one of the southern states for the year 1942. This county has a population of approximately 50,000, seventy-seven per cent of which is colored. The budget for maintaining this department totals \$40,840, approximately eighty cents per capital. More than fifty per cent of these funds was derived from local sources. The staff consisted of one full-time physician as health officer, two inspectors, six public health nurses, one dental hygienist, one laboratory technician, two clerks, and one part-time veterinarian for meat inspection. The budget also provided an item for the payment of local physicians for services rendered in the public health program.

Any community where seventy-seven per cent of the population is colored naturally presents formidable public health problems. What then, were the results accomplished in this country? All of the homes in every municipality in this county had been provided with a safe method of excreta disposal, either by means of water carriage systems or sanitary privies. Ninety-seven per cent of the school children of the county are provided with a safe method of excreta disposal; eighty-one per cent of the school children are served with a protected water supply; and seventy-seven per cent with adequate hand-washing facilities. Eighty-nine per cent of the public milk supply in that county is pasteurized. The general death rate was 8.8, in comparison with a rate of 10.3 for the registration area of the United States. The maternal death rate and infant mortality rate, which are regarded as two of the most delicate indices of an effective public health program, are strikingly significant, particularly when it is realized that eighty-eight per cent of all births in this county are delivered by midwives. The infant mortality rate was 35.9, and the maternal death rate was 2.9 per thousand live births. These rates are considerably lower than those of the registration area of the United States. Apparently, the health department has performed an Herculean task in teaching the midwives in that county the value of soap and water cleanliness and the dangers of needless meddling in cases of obstetricts. The achievements in this county can be duplicated anywhere in the United States, wherever there exists teamwork between the public health officials and the medical and allied professions.

The organization and inauguration of a sane and sensible public health program on a state-wide basis is an Herculean task fraught with trials, tribulations, and terrific obstacles. Persistence, determination and intelligent leadership are essential requirements for ultimate success. To supply that leadership in this state constitutes a real challenge to the members of this association. It is hoped that this challenge will be accepted and that efforts will be so persistently applied that the result will be a public health organization and program of which this association and the people of this state will be justly proud. During this organization period the crying need will be for real men, imbued with a spirit of loyalty to the best interest of scientific medicine, actuated by a determination to see that the task is effectively done in spite of all obstacles, absolutely immune to the seductive call of politics, and motivated by an insatiable desire to render efficient service to humanity and by an enthusiasm characteristic of one engaged in a life-saving enterprise.

Nature, in the production of disease, is uniform and consistent, so much so, that for the same diseases in different persons the symptoms are for the most part the same; and the selfsame phenomena that you would observe in the sickness of a Socrates, you would observe in the sickness of a simpleton.—Thomas Sydenham (1624-89).

In the three years following the last war more people died from famine and preventable disease than were killed in the war itself, hence the importance attached to the present organization of postwar relief. The principal regional medical officer, British Ministry of Health, holds that the lives and health of millions in Europe as well as the physique and welfare of a generation to come depends on how well this preparatory work is done. He visualizes four principal problems—the provision of food, the supply of medical necessities, the control of such diseases as typhus, malaria, tuberculosis, and dysentery, and the reestablishment of the medical, hospital, and public health services in each country.—Ed. Jour. Royal Inst. Pub. Health & Hyg.

After the war the numbers of men and women in the country will be practically equal is suggested by a report from Metropolitan Life Insurance Company statistics. The peak sex ratio of 1,060 males to every 1,000 females was reached in 1910, following a decade of the "greatest voluntary movement of population the world has probably ever seen." Since then the ratio of men to women has been steadily dropping. In 1940 it was 1,007 males to every 1,000 females. Since then (1940), there have been important changes arising from the war conditions. Many areas have suffered a loss of population to newly expanding industrial centers. All areas have undergone a withdrawal of men for military service. The outlook is that our postwar society may be constituted of practically equal numbers of men and women, and without such marked variations in different parts of the country as were found in the past.-Science.

MENINGOCOCCIC MENINGI-TIS AND THE WATER-HOUSE-FRIEDERICHSEN SYNDROME*

Hughes W. Day, M.D.

Kansas City, Kansas

Meningococcic meningitis, quoting a phrase from one of David's Psalms, is no longer a "terror by night nor the destruction that wasteth at noon-day." Just five years ago the diagnosis of epidemic cerebral spinal fever carried with it a grave prognosis and a haunting dread of serious permanent complications for those who recovered. Today meningococcic meningitis falls to the conquest of modern medical science, and heroic medical treatment.

As the young physician leaves the doors of the university with the newly acquired degree of doctor of medicine, he carries with him a knowledge of the characteristic symptomotology of disease. It is only after clinical experience and observation that unusual manifestations of such clinical disease become a part of his own knowledge, enhancing his acumen as a diagnostician.

Tonight, we wish to discuss the clinical features of this disease, and to point out pitfalls to be avoided in the establishing of an early diagnosis.

Meningococcic meningitis is caused by a Gramnegative diplococcus which gains entrance to the central nervous system through the nasopharynx, producing a diffuse, purulent change in the meninges. The spinal fluid in meningococcic meningitis is cloudy, under increased pressure, the cell-count varying from 3,000 to 30,000, containing the meningococcus demonstrated by a Gram's stain on direct smears.

At times, early in the disease, the organisms are best identified by culture of the spinal fluid in brain-broth, the bacteria growing abundantly in from twelve to twenty-four hours. We feel, therefore, that it is advisable to culture the spinal fluid in every case. Generally speaking, a patient with increased cell-count showing a predominance of polymorphonuclear cells should be considered a victim of meningococcic meningitis until proven otherwise.

The disease has been called epidemic meningitis, epidemic cerebral spinal fever, and spotted fever, for a certain percentage of patients show petechia and purpura. Before the advent of sulfonamide therapy the mortality rate was especially high among the "spotted fever" patients.

Typically meningococcic meningitis has an abrupt

* Presented before the Wyandotte County Medical Society on March 21, 1944.

onset with high fever, headache, vomiting and increasing delirium and coma. Nuchal rigidity is marked with the Kernig and Brudzinski signs positive.

CASE REPORTS

Our first case is essentially a text-book picture of the disease: Mrs. J. L., age thirty-six, was admitted to Bethany Hospital at 6 a. m. on April 4, 1943. She had awakened at 3 a. m. with severe headache and vomiting. Her admitting temperature at the hospital was 104.8 degrees, with all characteristic neurological findings present, including delirium. Under general anesthesia by Dr. Fulton, a rhachicentesis was performed with a cell-count of 14,000, four plus Pandy, a total protein of 120 mg. per cent, sugar, 100 mg. per cent and a meningeal gold curve. Meningococcic organisms were identified by direct smear and culture.

The patient was treated with ten grams of sodium sulfadiazine in 250 cc. of distilled water intravenously at 8 a. m. and reported at 8 p. m. the evening of admittance. The following day, five grams were given intravenously and on the third hospital day sulfadiazine was given by mouth in a dosage of one gram every four to six hours. The drug was discontinued on the patient's sixth hospital day. Her recovery was uneventful and she was dismissed on the twenty-fourth hospital day.

We believe that it is important to rapidly build up the blood and spinal fluid level in an acute meningococcic meningeal infection. We prefer for the first twenty-four to forty-eight hours to maintain a blood and spinal fluid of from ten to fifteen mg. per cent. It has been our experience that the spinal fluid level corresponds closely to the blood level. We also feel that fluid intake of at least 2000 cc. in twenty-four hours is very important. A daily or semi-daily blood count, urinalysis and blood and spinal fluid sulfa level is advisable during the first three or four days.

General ether anesthesia in our experience has been a definite aid in the performance of spinal or cisternal punctures when the patient is maniacal. This not only facilitates the ease in which the rhachicentesis is performed, but also acts as a therapeutic agent in producing relaxation and rest for the delirious patient. We feel that repeated spinal punctures at least every ten to twelve hours for the first two or three days is still good treatment. Pressure readings in millimeters of water should always be made. Signs of block should be observed and, if present, cisternal punctures are mandatory. We do not use intra-thecal drugs, and mention it only to point out that an aseptic meningitis may result from such a route of therapy.¹

At times these patients with meningitis may develop mild nitrogenous retention and some abnormal urinary findings. We prefer to check the blood NPN frequently during the first two weeks and if the fluid intake has been adequate, as the patient recovers, the blood chemistry returns to normal. Codiene, gr. one-half hypodermically is, in our experience, the best drug to relieve headache and restlessness. Occasionally we have augmented this with sodium phenobarbital or paraldehyde. I believe that morphine should not be used. In addition to sulfadiazine intravenously in the critically ill patient, we have occasionally employed Parke-Davis meningococcic meningitis antitoxin, giving from 20,000 to 40,000 units intravenously in 500 cc. of normal saline preceded by a skin sensitivity test and accompanied by four or five minms. of adrenalin in the saline.

This disease may vary in the length of time from onset until the patient is comatose. Dr. L. V. H., a patient of Dr. Ray Busenbark, was admitted to Bethany Hospital at 10 a. m. the morning of July 19, complaining of mild headache associated with a diarrhea, present approximately seven hours before admittance. His white count on admittance to the hospital was 24,850 (all of the patients with meningitis which we have seen have had an admitting white count of over 16,000). I saw Dr. H. at 11 p. m. the night of admittance at which time he was slightly irrational with petechia of both conjunctiva and upper thorax. No stiffness of the neck was present. The Kernig sign was negative. His temperature was 103.8 degrees.

Rhachicentesis under local anesthesia was performed and the diagnosis made. He was treated similarly to our first patient, with intravenous sulfadiazine, meningococcic meningitis antitoxin and repeated spinal punctures.

Careful observation may be necessary to make an accurate diagnosis. J. T., a boy aged seven, was admitted to Bethany Hospital at 6 p. m., December 22, 1943, with a temperature of 107 degrees. The boy was delirious and coughing. Auscultation of the chest revealed no positive findings. Neurological examination was essentially negative. A portable chest plate definitely ruled out a pneumonia. When the child was seen again at 8:30 p. m. marked nuchal rigidity and positive meningeal signs were present. Under general anesthesia rhachicentesis was performed and treatment instituted.

Temperatures of 105 degrees or over carry with them the suspicion of meningocerebral disease and one should suspect or rule out meningitis. We have recently seen a patient of Dr. Huber's however, with an admitting temperature of 98.8 degrees, so one must not exclude the disease because of a normal temperature.

The technic of spinal puncture is not difficult and if the attending physician feels that there is any suspicion of meningitis one should be performed and repeated as indicated. One negative spinal puncture does not exclude the disease.

Mrs. N. R., a white female, aged fifty-three, a patient of Dr. Busenbark, was admitted to Bethany Hospital December 6, 1943, at 11 p. m. complaining of headache, vomiting, and a fever of 104 degrees. She had become ill forty-eight hours prior to admittance but was not irrational. Mild nuchal rigidity was present, associated with definite petechiae. A spinal puncture performed on the evening of admittance revealed a normal pressure of 130 mm. of water, a negative Pandy and a cell-count of two. The following morning a definite clinical change was noted with additional petechiae and purpura, and increased stiffness of the neck. The Kernig test was suggestive. A spinal puncture performed at 11 a. m. revealed a pressure of 350 mm. of water, a cloudy fluid and a cell-count of 8,000 with meningococci present.

The patient was intensively treated with intravenous sulfadiazine, meningococcic antitoxin and adrenal cortex, three cc. hypodermically every three hours. Because of a reduction in the systolic blood pressure during the night and signs of increasing petechiae with purpura, it was feared that a Waterhouse-Friederichsen Syndrome was developing.

The Waterhouse-Friederichsen syndrome is seen chiefly in children and young adults. Approximately forty per cent of the cases are due to a fulminating meningococcemia, the remainder of the cases being due to various other organisms such as the streptococcus, staphlococcus, pneumococcus and Friedlander baccilus. The disease is characterized by an abrupt onset with fever, malaise, generalized muscular pain and vomiting. No neurological signs are present in the great majority of cases. In the first few hours of the disease, petechiae make their appearance with diffuse purpura developing rather rapidly. There is also associated with the purpura a reduction in the platelet count. A blood culture reveals the type of organism producing the syndrome. In the majority of cases the disease is quite fulminating with death occurring in six to twenty-four hours from the onset. The spinal fluid is essentially negative. However, if the patient survives the first twenty-four hours, signs of meningitis are present. The characteristic pathology at autopsy includes petechiae and purpura of the skin with scattered petechiae over the serosal surfaces of the visceral and parietal peritoneum. The

outstanding pathological finding is bilateral massive adrenal hemorrhage.

We wish to report two cases which we believe were due to this syndrome. Mrs. M. S., aged sixtyone, a patient of Dr. E. R. Millis was admitted to Bethany Hospital March 21, 1943, with a temperature of 101 degrees, having become ill at 3 p. m. at the date of admittance. When she was seen at 6 p. m., the patient appeared acutely ill, and was semiconscious. No pathologic neurological findings were present. Petechiae were seen along the upper extremities and over the thorax. There was a past history of having had some teeth extracted several weeks prior to her illness. She had complained of pain along the course of her lower left jaw earlier in the day and had taken five Anacin tablets for relief. We felt that the patient possibly had a septicemia and a blood culture was ordered. At 1 a. m. the patient presented signs of shock with a diffuse purpura over the entire body. Her platelet count was 90,000. She was given several blood transfusions and adrenal cortex extract but expired at 6 a. m. The striking pathological finding at autopsy was bilateral adrenal hemorrhage. Each adrenal was entirely replaced by blood-clot and was approximately the size of an ordinary hen's egg. Unfortunately the blood culture was never drawn. At the time of death it was thought that she had an acute thrombocytopenic purpura probably due to quinine in the Anacin. In retrospect, we believe that this was a Waterhouse-Friederchsen syndrome.

C. S. S., a one-year old baby girl, a patient of Dr. John H. Luke, was admitted to Bethany Hospital at 1 a. m., January 22, 1944. The child had become acutely ill approximately three hours prior to admittance. Petechiae and purpura were present with a temperature of 106.2 degrees on hospitalization. Death occurred one hour later. At autopsy the above findings were present associated with bilateral adrenal hemorrhage. No meningitis was present although a non-hemolytic streptococcus was cultured from the blood and spinal fluid.

We believe, therefore, that such a patient presenting the clinical features of the Waterhouse-Friederichsen syndrome should have immediate and intensive sulfa or penicillin therapy accompanied by massive doses of adrenal cortex extract and appropriate antitoxin. This syndrome, as well as meningococcic meningitis, is a definite medical emergency, but an emergency that we, as physicians, can meet successfully with early, effective and intensive therapy.

URETERAL CALCULUS — VISERO UROLOGIC COMPLEXES*

O. W. Davidson, M.D.

Kansas City, Kansas

Recurrent attacks of R.L.Q. pain following an appendectomy frequently brings the patient in for urologic study.

The following case summary is an example of no small number of such urologic records. It is the history of a white male, age thirty-eight, who had experienced attacks of R.L.Q. pain and associated gastro intestinal disturbances such as nausea, vomiting and distention, over a period of several months.

The diagnosis of acute appendicitis was made during one of these attacks. The urine specimen showed an occasional pus cell, WBC 12,100, Polys eightysix per cent. Due to the intensity of acute abdominal symptoms little or no importance was attached to the suggestion shown on a scout film of the abdomen as indicated in figure I.



M.38.PAIN ACUTE R.L.Q.
3 FORMER ATTACKS.
TEMP. HIGH WBC & POLYS.
URINE NORMAL.
APPENDECTOMY SL. CHR.
P.O.ABD.COLIC - GAS.
2 MO. LATER SHOCK
OPACATIES RI. KIDNEY.
5 MO. LATER R.L.Q.PAIN.
URETER STONE REMOVED.

Fig. I

A calculus in the ureter may, and often does, stimulate responses in the gastro intestinal tract in such a manner as to almost, if not completely, mask its identity.

Following removal of the appendix in this instance there was a period of apparent normal convalescense. Just before he left the hospital however, he was seized with a severe recurrent colicy pain, broke out in a cold, clammy perspiration and again had considerable abdominal distention.

Pathologic report on the appendix: walls slightly thickened, mucosa soft and velvety, no evidence of ulceration.

About two months after the first admission the patient was readmitted to the hospital in shock. Severe pain in the right loin. History of three such attacks while at home. Abdomen markedly distended and red from turpentine stupes. Systolic

^{1.} Boyd's Pathology of Internal Diseases.

^{*} The fourth of a series prepared for the Journal of the Kansas Medical Society.

blood pressure was eighty. He was cyanotic, and there was cold, clammy sweating. WBC 9,100, Polys seventy-nine per cent. Urine essentially normal. Diagnosis was made of suprarenal shock.

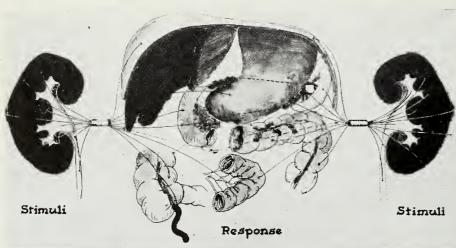
Scout film of abdomen (figure II) made at this time showed five definite rounded shadows in right

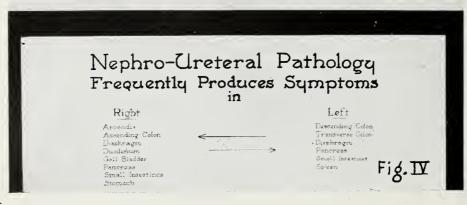
kidney area in addition to the shadow previously mentioned and indicated in figure I.

The patient, having been returned to his room while the film was being developed and given a high enema, was returned to x-ray. At this time the









film showed only three shadows. Examination of the bed pan revealed two asafetida pills.

The patient was dismised after ten days treatment with enemas, etc., feeling quite well. He experienced three more attacks of pain and associated abdominal disturbances during the next four months.

He then returned to the hospital for urologic study at which time difficulty was encountered in passage of a right ureteral catheter. Pyelogram (figure III) revealed essentially normal kidney pelves and additional evi-(Cont. on Page 278)

President's Page

To the Members of the Kansas Medical Society:

In this issue of the Journal is published a list of the members of the various committees for the year 1944-1945. Please read it over, so you will know who to call on if anything comes up that should be referred to a committee.

The success of this Society depends largely on how seriously the members take their committee assignments.

The Medical Economics Committee has gone about as far as it can on the Kansas Physician's Service pre-payment insurance plan until preliminary details can be worked out with the State Insurance Commissioner.

We are all glad to learn that Dr. J. L. Lattimore, of Topeka, who was a candidate for the legislature from the thirty-fifth district, won the primary election by about a two to one vote. We hope he does as well in the general election. We are also glad to know Dr. W. W. Andrews, of Kansas City, Kansas, is to be a candidate for the legislature. He had no opposition in the primary.

Sincerely,

M. Trueheart. M. D.

President, the Kansas Medical Society

EDITORIALS

NEW COMMITTEES

Dr. Marion Trueheart, of Sterling, president of the Society announces in this issue of the Journal, his new committee appointments for the year 1944-1945. The 241 committee members who will serve on the twenty-nine committees have been carefully selected by Dr. Trueheart, and it is believed that every county, district and society in the state is represented.

Two committees have been dropped this year, namely the Committee on Appendicitis and the Committee on Automobile Accidents and Fractures, and the new Committee on Post Graduate Study has been added.

All of the committees are faced with additional problems because of the war. The E.M.I.C. program, the instigation of the Kansas Physician's Service, the rehabilitation program, post graduate program, and legislative matters will all demand considerable society activity the coming year. The growth and progress of the Society depends to a large measure on the committee activity during the year and Dr. Trueheart has chosen carefully the men who will promote the medical program for the state.

PENICILLIN DEPOTS

In another section of this issue of the Journal will be found a list of the penicillin depots in the state of Kansas. Allocation to each hospital was made by the War Production Board, aided by an advisory panel composed of the National Research Council, the United States Public Health Service and the American Medical Association. The "depot hospitals" will be permitted to purchase a monthly quota and other hospitals in the vicinity may then purchase needed supply of the drug from the depots.

Hospitals desiring to be placed on the list to become penicillin depots may apply to the office of Penicillin Distribution in Chicago. Dr. F. C. Beelman, of the Kansas State Board of Health has informed us that a small supply of the drug will be available at all times at the Board of Health for emergency use and can be sent to individual physicians throughout the state when needed.

Because of the enterprise and initiative of many pharmaceutical houses and industrial plants in this country the supply of penicillin has been increased, to an unbelievable extent, and is now available for civilian use in designated hospitals throughout the country.

The use or abuse of the drug will be in the hands of physicians and it is hoped that the Kansas doctors of medicine will keep in mind that the supply is limited and use the drug judiciously. Penicillin has been proven capable of remarkable therapeutic treatment and a table published in a recent Journal of the American Medical Association gives in brief the latest uses and findings on the drug.

URETERAL CALCULUS-VISCERO UROLOGIC COMPLEXES

(Continued from Page 276)

dence concerning the small pelvic shadow previously mentioned.

The right ureteral catheter was left in place for thirty-six hours and no further attempts were made on this admission to dislodge the stone.

Patient left the hospital, remained free of pain and abdominal discomfort. Six days later in the office, in an effort to identify the stone and catheterize the ureter, a wax tip ureteral catheter was passed on the right. On withdrawal of the wax tip from lower end of ureter, the stone pulled out into the bladder, from which it was extracted with cystoscopic forceps.

The right ureter was catheterized at intervals for a time after this stone was removed. Over a period now of ten years this patient has suffered no more recurrences of right lower quadrant pain.

The above diagram (figure IV) is presented for the purpose of calling attention to the usual points to which nephro-ureteral pathology is often referred.

The fact that questions, concerning persistence of such R.L.Q. or generalized abdominal pains after appendectomy or other procedures, become urologic problems would seem to indicate the virtue of early urologic study.

That parachuting British medical units to care for the wounded in the advance line of action proved successful in the Tunisian campaign is reported by the London correspondent of the Journal of the American Medical Association. This revolutionary advance in army medical service may lead to the adoption of air-borne medical units on a large scale by the British Army. At present only the air corps is equipped to land surgeons and ambulance units by parachute and glider. A medical unit consisting of ten men, including a surgeon lieutenant, was dropped by parachute close to the line of battle in the Tunisian campaign. During one day alone his unit attended 162 wounded. Due to the medical attention made immediately available by this means, the lives of all but one man were saved. The unit arrived complet with full dressing station equipment, operating apparatus and instruments, anesthetics, sterilizers, medicines and dressings. Normally an air-borne medical unit can assemble its operating equipment within ten minutes of landing. Sufficient medical supplies and food are carried with the unit to last for several days without supplementary supplies.—Science.

MEN IN SERVICE

Lt. David Tappon, of Salina, was graduated as aviation medical examiner from the School of Aviation Medicine at Randolph Field, Texas, in the exercises held on May 17.

Recent issues of the Sedgwick County Medical Bulletin include the following service news:

"Incidentally, we are somewhere in New Guinea, the land of never ending summer, and close enough to the equator to be really tropical. We have two seasons — the wet, and the dry — and are just finishing the former. The mean temperature variation is only five degrees. Sailed from Frisco . . . arrived in Australia . . . May give you some idea of how far away from the U. S. we really are. A point some . . . west of us is almost exactly half the way round the world from New York City, so you see if we get much farther we will be on our way home. Have been in New Guinea about four months now after spending about two months in Australia. Am in the best of health and believe we are doing a good job," writes Major H. W. Palmer, of Wichita.

Lt. Comdr. H. F. O'Donnell, of Wichita, writes: "I spent several months at a large hospital on the coast. For the first few weeks, I was somewhat overwhelmed at the sudden change but after becoming indoctrinated into the custom of the Navy and accustomed to the paper work, we began to enjoy life. In the fall I had some leave and we spent ten days at a Lodge on the Klamath River, fishing. I found time to take care of a large ward of urological patients, together with my share of consultation work in a 14,000-bed hospital. We had lots of diagnostic work and a moderate amount of surgery. Since leaving Wichita, I have seen Wier (Lt. Comdr. C. H. Wier), Hibbard (Lt. Comdr. J. S. Hibbard), Donnell (Lt. L. A. Donnell), Adams (Lt. A. J. Adams), MacLeod (Lt. Sherburne Mac-Leod) and Palmer (Major H. W. Palmer). They all looked fine at the time I saw them. About the first of the year I was sent out here. Have been here only a short time but am extremely well pleased with my duty. Our hospital is at last as well equipped as any at home. The personnel is of the finest, and I feel quite fortunate to be associated with such a group of men. I am impressed with the high quality of physicians that I have met in all branches of the service, and, although this is undoubtedly a young man's war there are dozens who are in their middle and late forties, men who have given up large and lucrative practices for the duration and without complain-

"We are extremely busy most of the time, but also have short periods with little more to do than routine duties. These periods are welcome if they don't last too long. For recreation we have opportunities for fishing, swimming, hiking and sight-seeing; also frequent movies and other entertainment. I have not felt as well since my high school days, and up to now there has been no monotony. Yesterday we went to a Recreation Center on a rather secluded and beautiful beach. Just off the dock were some markers, one pointing off over the water and reading, San Francisco???? miles. Can't state the distance but it's a hell of a long swim.

'It's hard to visualize Wichita as it must be today . . .

Know that you all must be working to the limit, and hope it won't be long before the rest of us can rejoin you."

Major M. R. Blacker, of Wichita, is at Balboa Island, California, and Lt. P. B. Young, of Wichita, is at Randolph Field, Texas, in the School of Aviation Medicine.

Lt. Col. E. B. Ross, of Wichita, formerly stationed at Brownwood, Texas, is now in North Africa, according to the Bulletin. Lt. Col. Ross is commanding officer of a field hospital.

Lt. H. O. Anderson, of Wichita, writes the Bulletin as follows: "I am sitting just outside my tent on the side of a hill in North Africa. Col. Ross (Lt. Col. E. B. Ross) is on the opposite side about one-fourth mile away. It was a thrill reading the news from home. I didn't miss a word. I can't think of a thing which would be more welcome in a place like this. It made me forget the dirt, mud, heat, Arabs, and filth for a good hour. All types of experiences are plentiful here and we all get our share. The boys stationed in hospitals at home don't know what they are missing. They have all the conveniences of home plus a promotion every six months. We are stationed, I believe, in the same place as Wayne Bartlett's unit (Major W. C. Bartlett). A beautiful spot as far as scenery is concerned. Olive trees, figs, dates, oranges and lemon trees all loaded with fruit. The people are French and Arabic, and very poor. The invasion drained them of all their food and supplies. They all seem to have plenty of money but no clothes or food. Some of the boys have gotten as much as \$10.00 for a pair of cotton pants which they paid \$2.00 for at home. As yet, we are not definitely located but hope to be shortly. We know very little about the war news. Anyone anticipating a trip to North Africa would do well to bring candles along for light. We all go to bed at 8:00 p.m. It's to dark to do anything else. Have been perfectly well since I joined up, and it's an experience well worth having.'

Major Charles E. Basham, of Eureka, requests that his Journal be sent to his new address. Major Basham has an APO address out of New York.

Major Kenneth W. Haworth, of Pratt, stationed at Indiantown Gap, Pennsylvania, has advised us that he has an APO address out of New York.

We have been advised that Major Orville Clarke, of Topeka, has a new APO number out of New York.

Major W. J. Kiser, of Wichita, has been transferred from Victorville, California, to Los Vegas, Nevada.

Capt. H. O. Williams, of Peabody, has been transferred from Fort Ord, California, to Camp Ellis, Illinois.

Major M. R. Blacker, of Wichita, has been transferred from the Army Air Base hospital at Portland, Oregon, to an APO out of New York.

Lt. C. Van Pelt, of Junction City, is now stationed at Seattle, Washington.

Lt. Harold F. Spencer, of Garnett, now stationed at Minneapolis, Minnesota, recently attended a six months

course in anesthesia at Hahnamann Hospital in Philadelphia, Pennsylvania, and later received special instruction at Temple University and in the United States Naval Hospital.

Dr. Myron W. Husband, director of the Kansas State College department of student health, has been commissioned a lieutenant commander in the Navy and reported for duty on July 24. Dr. Husband assumed his duties at the College in 1935 and is on leave for military service.

According to a Wichita Eagle news item: "Capt. I. B. Putnam, former Wichita physician, was a member of a paratroop division which invaded France on June 6. Captain Putnam received his first mail following D-day on June 18, he informed friends here in a letter recently. June 18 was also the first day since the invasion day that he had been able to remove his paratrooper boots."

"Dr. Norris Robertson, of St. Louis (according to the Concordia Blade-Empire) of Concordia, has received a commission as a lieutenant in the Navy. He will report for service at the U. S. Naval Hospital at Corona, California, on July 21. During the past two years Dr. Robertson has been conducting an eye clinic and teaching opthalmology at Washington University and Barnes Hospital at St. Louis." Lt. Robertson is the son of Dr. and Mrs. E. N. Robertson, of Concordia.

Dr. Porter Clark, of Independence, received his commission as lieutenant commander in the Navy and reported for duty in San Diego, California, on July 31.

Capt. Letteer Lewis, of McPherson, writes: "Will you please change my APO address."

The British Medical Journal and Lancet report on the use of penicillin in the Sicily and North Africa theatres of war. Physicians are enthusiastic about results in war wounds for prevention or control of infection with pyogenic cocci. Surgeons can now suture gunshot wounds without fear of spread of infection to the blood stream and there is saving of life, limb, fighting-man hours, dressings, hospital service, equipment and transportation. Wounds treated with penicillin healed from three to six weeks faster.—R.N.

"The German prisoner captured in Italy is a husky, wellfed, well-equipped youth. He's glad to be out of the war, but he's confident that Hitler will win in about a year and no one can tell him that New York hasn't been bombed," says Capt. Louis J. Crum, of Cincinnati.

"To insure prompt treatment by experts, of men wounded in battle, surgery has gone up to the front lines. The result is that hospital fatalities in this war are less than half of the number experienced in the World War. The War Department announced on February 1 that hundreds of highly skilled surgeons, technicians, and surgical nurses are organized in every theater of operations where American troops are fighting. These auxiliary surgical groups have their own equipment, tents, and special trucks. Such surgical groups are now in this war.

"A general team may consist of general surgeon, an assistant surgeon, an anesthetist, a nurse, and two surgical technicians. With them go truck drivers and other assistants. These teams, like firemen, are always ready to go on call when and where they are needed. They are not burdened with routine duties and are not attached to any particular organization. They may be assigned by the theater surgeon to go anywhere in a battle area where men

need immediate special attention. They may travel in supply vehicles, in jeeps, or by plane—the primary motive being to get where they are needed speedily.

"In jungles where wheeled vehicles cannot move, they have portable surgical hospitals. These teams of four officers and thirty-three enlisted men load their instruments, tents, dressings, and medicines on their backs and catry them forward as far as they are allowed to go. They set up under canvas and begin work often under fire.—U. S. Army Med. Department Bulletin.

(The following story was taken from the Pennsylvania Medical Journal—written by a Technical Sergeant who is a Marine Corps Combat correspondent, and a former reporter on the Pittsburgh, Pa. Press): "Bougainville—(Delayed) — Cut into the narrow back-bone of 'Hellzapopppin' Ridge,' dangerously close to the front lines, there is an aid station where a tired little doctor and his hospital corpsmen utilize even the grass of the jungle to treat the ever-flowing line of Marine wounded for whom this is the first stop 'on the way back'."

"This is the only aid station up here," wearily said Lt. Edmond A. Utkewicz, 38, (MC), of Jersey City, N. J., member of the New Jersey State Medical Society, a kindfaced, slight little man with tired blue eyes. His shoulders drooped in fatigue as he squatted on his heels in the shallow foxhole aid station and puffed spasmodically on a cigaret.

A minute before he had treated a young Marine badly wounded in the abdomen and sent him off down the long, rugged trail with a cheerful pat and a silent prayer.

"I think that kid has a good chance," muttered "Doctor Ed" reflectively. "He has the will to live."

The doctor started to tell of the "wonderful morale of the wounded," but suddenly blurted out:

"Those Japs are out to get my corpsmen. They lie in wait for these boys until they crawl up to a wounded man. Then they open up. Right now I have only these two left in the station."

As the doctor talked Corpsman Garnet (of Virginia) looked up the trail and said laconically. "Here comes another." Then as the litter bearers moved closer, he ejaculated: "It's 'Fish'."

"Doctor Ed" sprang to his feet almost sobbing "'Fish' (Pharmacist's Mate Fisher of Mississippi) is one of the best men I've got," he said.

Corpsman Fisher was wounded in the right shoulder by a sniper's bullet which traveled downward and emerged from his back, apparently without striking any vital organ. Earlier, shrapnel from a mortar shell had inflicted a leg wound on Pharmacist's Mate Young of Texas, as he advanced with a Marine company.

The doctor and his two assistants remained too busy to talk much beyond saying they used "grass, leaves, and anything else we can find for splint padding, and rifles, split young trees, and boards from ration boxes for the splints."

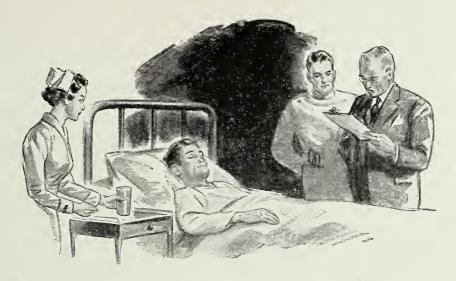
But farther back at the collecting station other doctors had time to tell of the magnificent work "Doctor Ed" and his boys are doing.

"They've been up there under fire without rest since this action started," one doctor said. "Once they were forced to evacuate because the Japs were dropping mortar shells around them. That spot still is a good target, but they went back and they'll stay there as long as a man needs attention."

"Doctor Ed" was a cancer specialist and formerly treated the ailing wings of the Jersey City International League Giants

"But I'm in the big leagues, now," he said, half-whimsically just before we left him.

AUGUST, 1944 281



Proteins...Vitamins...Minerals

AS SOON AS LIQUIDS ARE RETAINED

The insult of anesthesia, tissue manipulation, unavoidable trauma, and enforced starvation sharply raise the nutritional requirements of the postoperative patient. Hence feeding must be started as early as possible to prevent too great a nutritional imbalance. Also, recovery is hastened and strength is gained more quickly when postoperative metabolic needs are supplied adequately.

Usually tolerated as early as liquids are

retained, Ovaltine as a beverage provides a simple yet highly effective means of improving the nutritional state of the postsurgical patient. Its essential nutrients, well balanced and generously supplied, are in easily assimilated form. Thus the digestive burden is materially reduced. The delicious taste of this food drink proves appealing to all patients, young and old, making Ovaltine acceptable when many other foods are refused.

THE WANDER COMPANY, 360 North Michigan Avenue, Chicago 1, Illinois



Ovaltine

Three daily servings (1½ oz.) of Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE :	30.0 Gm.	62.43 Gm.	VITAMIN D : :	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE :	.9 mg.	1.296 mg.
CALCIUM :	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS :	.25 Gm.	.903 Gm.	NIACIN :	3.0 mg.	5.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg
*Each serving made	with 8 o	z. of milk;	based on average repo	rted values	for milk.

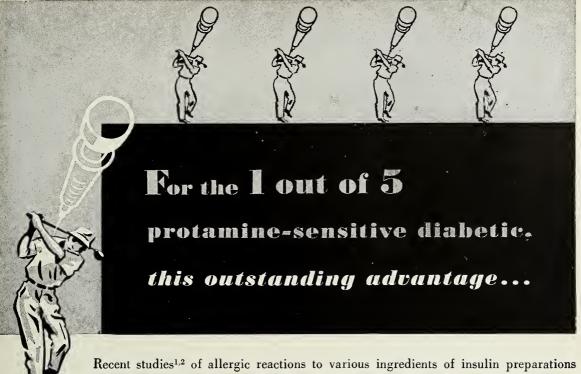
NEWS NOTES

10/1/10/15	COMMITTEES
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Dr. Marion Trueheart, of Sterling, president of the Kansas Medical Society announces the following Society committees will serve during the year 1944-1945:

mittees will serve during the year 1944-1945:	
ALLIED GROUPS	
George Milbank, M.D., Chairman	Wichita
L. L. Bresette, M.D.	Kansas City
O. R. Brittain, M.D.	Salina
B. L. Greever, M.D	Hutchinson
C. A. Hellwig, M.D.	Wichita
W. E. Janes, M.D	Eureka
R. R. Melton, M.D.	Marion
AUXILIARY	
C. Omer West, M.D., Chairman	Kansas City
W. Y. Herrick, M.D.	Wakeeney
E. J. Nodurfth, M.D.	Wichita
W. L. Pratt, M.D.	Leavenworth
R. W. Urie, M.D	Parsons
H. H. Woods, M.D.	Topeka
CHILD WELFARE	Topena
Paul E. Belknap, M.D., Chairman	Topeka
C. T. Hinshaw, M.D.	Wichita
O. C. McCandless, M.D	W Icinta
O. C. McCandless, M.D	Wanon
D. N. Medearis, M.D.	Kansas City
E. G. Padfield, M.D.	Salina
G. A. Westfall, M.D.,	Halstead
Dir. of Child Welfare, State Board of Health.	Торека
CONSERVATION OF EYESIGH	T
W. G. Gillett, M.D., Chairman	Wichita
J. A. Billingsley, M.D.	Kansas City
L. R. Haas, M.D.	
J. G. Janney, M.D.	Dodge City
L. A. Latimer, M.D.	
W. W. Reed, M.D.	Topeka
E. N. Robertson, M.D.	Concordia
E. E. Tippin, M.D.	*****
	Wichita
D. D. Vermillion, M.D.	Goodland
D. D. Vermillion, M.D.	Goodland
D. D. Vermillion, M.D	Goodland G
D. D. Vermillion, M.DCONSERVATION OF HEARING. J. H. Enns, M.D., Chairman	Goodland G Newton
D. D. Vermillion, M.D	Goodland G Newton Topeka
D. D. Vermillion, M.D	Goodland G Newton Topeka McPherson
D. D. Vermillion, M.D	Goodland G Newton Topeka McPherson Salina
D. D. Vermillion, M.D	Goodland G Newton Topeka McPherson Salina Wichita
D. D. Vermillion, M.D	Goodland GNewton Topeka McPherson Salina Wichita
D. D. Vermillion, M.D	Goodland GNewton Topeka McPherson Salina Wichita Paola Winfield
D. D. Vermillion, M.D	Goodland GNewtonTopekaMcPhersonSalinaWichitaPaolaWinfieldSabetha
D. D. Vermillion, M.D	Goodland GNewton TopekaMcPherson SalinaVichitaPaolaWinfieldSabetha Junction City
D. D. Vermillion, M.D	Goodland GNewton TopekaMcPherson SalinaWichitaPaolaWinfieldSabetha Junction City
D. D. Vermillion, M.D	Goodland GNewtonTopekaMcPhersonSalinaWichitaWinfieldSabetha Junction City SWichita
D. D. Vermillion, M.D	Goodland GNewtonTopekaMcPhersonSalinaWichitaSabetha Junction City SWichita
D. D. Vermillion, M.D	Goodland GNewton TopekaMcPherson Salina Wichita PaolaWinfieldSabetha Junction City SWichitaWichitaKirned Kingman
D. D. Vermillion, M.D	Goodland GNewtonTopekaMcPhersonSalinaWichitaPaolaWinfieldSabetha Junction City SWichitaLarnedKingmanOsborne
D. D. Vermillion, M.D	Goodland GNewtonTopekaMcPhersonSalinaWichitaPaolaWinfieldSabetha Junction City SWichitaLarnedKingmanOsborne
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D. D. Vermillion, M.D	Goodland GNewtonTopekaMcPhersonSalinaWichitaPaolaWinfieldSabetha Junction City SWichitaLarnedKingmanOsborneWaterville
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(1) Page, R. C., and Bauman, L.: J.A.M.A. 124:704 (March 11) 1944. • (2) Bauman, L.: Bull. N. E. Med. Cen. V:17-21 (Feb.) 1943. • (3) Bauman, L.: Am. J. Med. Sc. 198:475 (Oct.) 1939, ibid. 200:299, 1940. • (4) Duncan, G. G., Diseases of Metabolism, Phila., Saunders Co., 1942, p. 782.

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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

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KANSAS HOSPITALS APPROVED FOR PENICILLIN DEPOTS

John N. McDonnell, director of the office of civilian penicillin distribution, of the War Production Board, in Chicago, Illinois, has announced that fifty-three civilian hospitals in the state of Kansas have been approved for penicillin depots for the distribution of the drug, as of June 1, 1944. In all approximately 2,000 hospitals in the country have been specially designated and approved to handle and distribute the new drug. The newly established depots will recognize requests for the drug from other hospitals when needed.

The following Kansas hospitals have been approved and are now serving as penicillin depots (the list does not, however, include state hospitals which are also approved):

Abilene-Dickinson County Memorial Hospital; Anthony—Gallaway Hospital; Atchison—Atchison Hospital; Beloit—Community Hospital; Chanute—Johnson Hospital; Coffeyville-Southeast Kansas Hospital; Colby-St. Thomas Hospital; Concordia-St. Joseph's Hospital; Dodge City -St. Anthony Hospital; El Dorado-Susan B. Allen Memorial Hospital; Ellsworth-Ellsworth Hospital; Emporia-Newman Memorial County Hospital; St. Marys-St. Mary's Hospital; Fort Scott—Mercy Hospital; Garden City—St. Catherine's Hospital; Great Bend—St. Rose Hospital; Halstead—Halstead Hospital; Hays—St. Anthony's Hospital; Hutchinson—Grace Hospital; Hutchinson-St. Elizabeth Mercy Hospital; Independence-Mercy Hospital; Junction City-Junction City Municipal Hospital; Kansas City-Bethany Hospital; Kansas City-Province Hospital; Kansas City-St. Margaret's Hospital; Kansas City-University of Kansas Hospital; Lawrence-Lawrence Memorial Hospital; Eudora (Lawrence) - Sunflower Ordnance Works Hospital; Leavenworth—Cushing Memorial Hospital; St. John-St. John Hospital; Manhattan-St. Mary's Hospital; McPherson-McPherson County Hospital; Mulvane-Atchison, Topeka & Santa Fe Railway Hospital; Newton-Axtel Christian Hospital; Newton-Bethel Deaconess Hospital; Ottawa-Ransom Memorial Hospital; Parsons-Mercy Hospital; Pittsburg-Mount Carmel Hospital; Pratt-Ninnescah Hospital; Sabetha-St. Anthony Murdock Memorial Hospital; Salina-Asbury Protestant Hospital; Salina—St. John's Hospital; Topeka-Atchison, Topeka & Santa Fe Railway Hospital; Topeka—Christ's Hospital; Topeka—Jane C. Stormont Hospital; Topeka—St. Francis Hospital; Topeka—Security Benefit Association Hospital; Wichita—St. Francis Hospital; Wichita—Sedgwick County Hospital; Wichita—Wesley Hospital; Wichita—Wichita Hospital; Winfield—St. Mary's Hospital; Winfield—William Newman Memorial Hospital.

ASHMORE GOVERNOR OF AMERICAN COLLEGE OF CHEST PHYSICIANS

Dr. A. L. Ashmore, of Wichita, was re-elected as the Governor of the American College of Chest Physicians for a three-year term, at the annual meeting of the organization held in Chicago, Illinois, on June 10-12. Dr. Ashmore and Dr. Homer L. Hiebert, of the Kansas State Board of Health in Topeka, were Kansas members who attended the annual meeting.

MARTIN BAKER NEW EXECUTIVE SECRETARY OF SEDGWICK COUNTY

Mr. Martin Baker, of Wichita, formerly music instructor of Wichita North High School, has been selected as the new executive secretary of the Sedgwick County Medical Society, whose offices are in the Schweiter Building. Mr. Baker, one of the fourteen applicants for the position left vacant when Oliver Ebel resigned to accept the executive secretaryship of the State Society, July 1, has been completing his masters' degree in Chicago and will assume his new duties on August 7.

LABORATORY TECHNICIANS SHORT COURSE

The Department of Zoology of the University Extension Division of the University of Kansas, at Lawrence, conducted a short course in Medical Helminthology for medical technicians on July 26-29. The lectures and laboratories were conducted by Miss Mary E. Larson, Assistant Professor of Zoology of the University.

The course of study in the field of tropical medicine covered the following: Nematoda, Cestoda, and Trematoda with the study of the life cycle, morphology and diagnosis of each.

NEW STATE SUPERVISING OPHTHAL-MOLOGIST

The Board of Social Welfare announced that effective July 1, 1944, Dr. William F. Abramson, of Topeka, had been appointed as State Supervising Ophthalmologist for the Division of Service for the Blind, of the Kansas State Board of Social Welfare, succeeding Dr. W. W. Reed, of Topeka.

The appointment is effective for an eighteen months period. Members of the Board of Social Welfare are as follows: Dr. David MacFarlane, of Emporia, Chairman; Mr. Ben Johnson, of Talmo, and Mr. Frank W. Durein, of Topeka.

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WOUNDED FLOWN FROM FRONTS

Recent news release informs us that some 7,000 wounded have been flown from the invasion front by the Army Air Force in three weeks. The Medical Corps has pressed into service a new "flying jeep" type of airplane to rush wounded Allied soldiers from the French invasion front to hospitals removed from the scene of battle. In a recent address, General Grant, as guest speaker of Schenley Laboratories, Inc., makers of penicillin, revealed in a coast to coast broadcast, that more than a quarter of a million sick and wounded, American and Allied, have been carried out of battle areas by military aircraft since Pearl Harbor. This number is being enlarged at the rate of about 1,000 patients a day, he reported.

Actual air operations on the Normandy beachhead, General Grant reported, "began on 'D-plus-four' as soon as engineers had built a runway on which the huge C-47 transport planes could land to receive their loads of sick

and wounded."

"A total of several hundred flight surgeons, flight nurses and enlisted technicians" General Grant said, "are assigned to this duty of bringing the wounded out of France under the protective cover of our flighter planes."

NEW HEALTH SERVICE HEAD FOR U. S. CHILDREN'S BUREAU

Dr. A. L. Van Horn has been appointed director of the Division of Health Service of the Children's Bureau of the United States Department of Labor, to succeed Dr. Edwin F. Daily, who is leaving to enter service. Dr. Betty Huse has taken Dr. Van Horn's place as assistant director for crippled children in the Division of Health Service.

Dr. Daily has been in charge of the emergency maternity

and infant care program.

Dr. Van Horn was born in Asheville, North Carolina, and was graduated from the University of Michigan Medical School. He completed six years of special training in pediatrics and became chief of the Bureau of Child Hygiene of the Ohio State Department of Health and went to the Children's Bureau in 1936 as regional medical consultant on crippled children. In 1937 he was made assistant director of the Crippled Children's Division and has been in charge of the services since 1941.

MEMBERS

The American Board of Obstetrics and Gynecology have announced that Dr. Robert E. Pfuetze, of Topeka, and Dr.

Hubert M. Floersch, of Kansas City, are Diplomates of that board.

Dr. Arthur E. Hertzler, of Halstead, had a surgery exhibit at the recent A.M.A. Meeting in Chicago, on June 12-16, with Dr. Irene A. Koeneke and Dr. Cora Dyck, of Halstead, in charge of the exhibit. The exhibit was on "Wound

CLASSIFIED ADVERTISEMENTS

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Dr. L. K. Chont, of Winfield, is the author of an article entitled "Adamantinoma" in a recent issue of the American Journal of Roentgenology and Radium Therapy, also abstracted in the July issue of the Digest of Treatment.

Dr. John A. Billingsley, of Kansas City, was elected as the first vice-president of the Kansas City Society of Opthalmology, Otology, Rhinology and Laryngology at the annual meeting of the Society held in Kansas City on May 25, 1944.

Dr. S. M. Hibbard, formerly of Sabetha and Topeka, has moved to Excelsior Springs, Missouri, where he is connected with the McCleary Clinic.

Dr. Paul Belknap, of Topeka, was elected as one of the four new directors of the Kansas Tuberculosis and Health Association at its annual meeting held in Topeka recently. Program speakers were: Dr. F. C. Beelman, of Topeka; Dr. H. L. Hiebert, of Topeka; Dr. C. E. Coburn, of Kansas City, and Capt. Elmer B. Reed, of the Winter General Hospital in Topeka.

Dr. F. L. Loveland, of Topeka, was appointed on June 21, by Governor Andrew Schoeppel to the advisory commission of the State Tuberculosis Sanatorium at Norton, for a four year term.

Dr. C. K. Schaffer, of Topeka, was appointed to the City-County Board of Health by the City Commission of Topeka, to succeed Dr. Wilson Hobart who recently resigned.

Dr. B. S. Rathert, formerly of Downs and Cawker City, has recently located in Seattle, Washington.

DEATH NOTICES

Word has been received in the central office of the death of Captain Jack (John F.) Austin, of Wichita, the executive secretary of the Sedgwick County Medical Society from 1937 to his enlistment in the service soon after Pearl Harbor. He was recently stationed at Fort Bliss, Texas, but was killed while on maneuvers in South Carolina, on August 4.

Dr. Thomas J. Hollingsworth, 89 years of age, died on July 10, at his home in South Haven. He was born in Butler, Missouri, on September 1, 1854, and was an honorary member of the Sumner County Medical Society.

More Americans have lost their lives in fires since 1900 than have been killed in all the wars fought by the United States (according to a recent announcement of the National Fire Protection Association. It is estimated that 425,000 persons have died as a result of fires in this country since the turn of the century.—Ohio State Medical Journal.

BUY A BOND FOR VICTORY

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

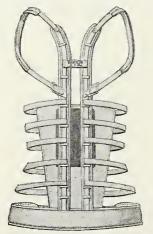
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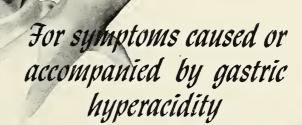


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EXECUTIVE OFFICE

GOVERNMENT MEDICINE

Senate Bill 1161 was a trial balloon that exploded. But its political potentialities had reverberated across the nation before this happened so that today America is aware of government medicine as an exhumed bone that politicians may wrangle over.

The prospect would be funny except for the incongruous position medicine occupies in this farce that is trying to become melodrama. If wide-spread government control of medicine is enacted it will be over the almost universal objections of the entire medical profession.

That in itself could offer a moment of sober reflection to a giddy revolutionist if he cared to survey the scene. A government that can throttle one profession and dispense its services by decree can also do the same for all other professions and business.

If it is pleasant to dole medical care to the citizens of this nation, for a small tax assessment, would it be less enjoyable to offer the benefits of religious service in similar fashion? The cost of maintaining our churches is badly distributed and government control could be planned on as benevolent a basis for the minister as for the doctor.

Of course, the doctor resents losing his rights to practice as he pleases. Bad as that prospect appears from here it is of less consequence than the sacrifice the public will make in the type of medical care to be received. But most devastating, we believe, is the precedent such action will afford the law makers of the future. A governing body that can socialize the practice of medicine can also socialize

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the legal profession and the automobile industry and the newspapers of our nation. Should that come to pass then what is left of the America that our boys died in battle to preserve?

Between rounds on this battle there are other issues to concern our attention. One of these has recently identified itself in a ruling that after July 1, pre-medical students will no longer be deferred from active service with the armed forces. Whether this is a deliberate act to support advocates of government medicine is an interesting question but it will strengthen their argument that a physician shortage exists.

This edict will eliminate every healthy male pre-medical student from further schooling. Next fall the freshman classes all over the nation will consist of women and afew 4-F's. Not a pleasant prospect in the face of the large numbers of physicians who drop out of practice each year. Unpleasant also is the future that medical schools are contemplating.

Procurement and Assignment exerted all possible pressure to change this order but to no avail. So now we face this paradox also humorous, if you like it grim:—Government control of medicine is advocated partly as a solution for the physician shortage and this, an official act of our government, more than anything else aggravates the shortage. Their answer is that the armed forces need men.

But there is something we can do even yet. On June 23, Congressman Miller, of Missouri, introduced H. R. 5128, which provides that not less than 6,000 medical and premedical students and not less than 4,000 dental and predental students shall be deferred in each calendar year. We can call this to the attention of our Congressmen. It is important.

Nor is this all. From the left there came an ally who offered to help us in our battle to retain independence. Perhaps we are wrong, but each time this ally tried to help it seemed to hinder us. Perhaps it was just clumsy and well-meaning but its nudges struck us more often than our opponents.

The U. S. Children's Bureau administers the Emergency Maternal and Infant Care Program. Through the courtesy of this federal agency you now are paid for obstetrical services rendered wives of enlisted men. But you are also restricted by federal regulation.

The Children's Bureau insists that it is their aim to help you. They pay you for services that these young mothers could not or would not pay you for. The patient, they claim, is not capable of handling sums of money as large as \$50.00 so you must be paid directly, by the government.

Since government medicine cannot be administered without regulations the Children's Bureau has fostered some that affect you, also. For instance, you will now accept government pay for all non-obstetric conditions that arise at the time of pregnancy. This is new. You recall that the program began as obstetrical service but their concept is enlarging.

Moreover the Children's Bureau objects to Kansas' method of selecting consultation service. The Kansas method, you know, is to use a doctor you have confidence in. In Washington it has been decided that where Diplomates of American Specialty Boards are available, these only may be used. In other places an avowed specialist whose work is exclusively in one field, and who meets all requirements of the National Board, may be used but he is designated as an assistant consultant.

Elsewhere in the areas where the doctor travels miles to see his patients, where necessity and a desire to be of serv-

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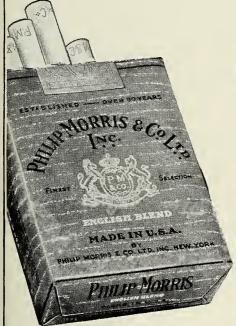
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

ice prompts him to do all types of practice, where he alone cares for the welfare of patients often without hospital facilities nearby, in those locations the Children's Bureau finds our method of selecting consultants highly unsatisfactory. There, they warn us solemnly, the County Society shall select one man who must do all the consultation work.

Of course, we may drop the EMIC if we want to be the only state out of the fold, if we are willing to run the gauntlet of whatever criticism the government wishes to heap on us, if we are willing to stand defenseless in the face of having our motives distorted to mercenary and un-

patriotic origin.

Your council is studying this problem and an effort will be made to compromise on this last edict. Further information will be given you but this introduction was included to assure you that our battle against federal control of our profession has not been won by defeating Senate Bill 1161. It is not finished even with an A.M.A. office in Washington nor after we offered to sell our own insurance against surgical and obstetric costs to all the residents of Kansas. It is not settled because the physicians in America have become indignant. It is not solved by a plan to unionize the profession, with right to strike, as offered by Gary, Indiana. Nor can we be victorious if we throw up our hands and cry surrender.

The advancements of medicine, the x-ray, insulin, sulfanilamide, penicillin and a host of other scientific aids in the practice of our art were discovered by free men who worked for the adventure which we know as individual enterprise. American medicine today has achieved worldwide supremacy because it has been unhampered. The lay person who understands this side of the picture does not want anything different. It then becomes our responsibility to inform the lay person of the interest he must take. If this can be done we will emerge free men as before and

stronger because of the confidence and good will afforded us by the community at large.

ACCIDENT AND HEALTH INSURANCE

One more announcement from the office. In May your House of Delegates made available to you an Accident and Health insurance policy at a reduced rate. The rate is cheaper because it is group insurance. Half the members of this Society must enroll before the plan becomes effective. It offers you broad coverage, is non-cancellable by the company and is unaffected by other insurance you carry.

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Babies can be infected with tuberculosis during the earliest days of life and such infection in certain cases tends to progress rapidly and often ends fatally. The diagnosis of tuberculous meningitis or generalized tuberculosis in an infant or child should initiate an immediate and intensive search for the source of infection. A. S. Pope, M.D., Journal of Pediatrics, March, 1942.

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BOOK NOOK

BOOKS RECEIVED

OFFICE TREATMENT OF THE NOSE, THROAT AND EAR—Abraham R. Hollender, M.Sc., M.D., F.A.C.S., Associate Professor of Laryngology, Rhinology and Otology of the University of Illinois College of Medicine and Otolaryngologist of the Research and Educational Hospitals of Chicago, Illinois. Published by the Year Book Publishers, Inc. of 304 South Dearborn, Chicago. The book of 340 pages, well illustrated is priced at \$5.00.

HEALTH EDUCATION ON THE INDUSTRIAL FRONT, The 1942 Health Education Conference of the New York Academy of Medicine. Published by the Columbia University Press of Morningside Heights, New York. This little book of sixty-three pages dealing with the problems arising from modern industrial conditions is priced at \$1.25.

NASCENT ENDOCRINE THERAPY—John Franklin Ritter, M.D. Published by the Caxton Printers, Ltd. Caldwell, Idaho. The review copy of the book was sent to the Journal office by courtesy of the author.

SYNOPSIS OF DISEASES OF THE HEART AND ARTERIES—George R. Herrmann, M.S., M.D., Ph.D., F.A.C.P., Professor of Medicine of the University of Texas, Director of Cardiovascular Service of John Sealy Hospital, and Consultant in Vascular Diseases of the United States Marine Hospital. Published by the C. V. Mosby Company

of St. Louis this Third Edition is priced at \$5.00 and contains 516 pages beautifully illustrated in black and white and in colors.

SYNOPSIS OF NEUROPSYCHIATRY—Lowell S. Selling, Sc.M., M.D., Ph.D., Dr. P.H., Director of Psychopathic Clinic, Recorder's Court of Detroit, Michigan, Associate Attending Neuropsychiatrist of Eloise Hospital; and Adjunct Attending Neuropsychiatrist of Harper Hospital. Published by the C. V. Mosby Company of St. Louis, the book is priced at \$5.00. There are 500 pages.

INDUSTRIAL OPHTHALMOLOGY — Hedwig S. Kuhn, M.D., of Hammond, Indiana. Published by the C. V. Mosby Company of St. Louis the book contains 294 pages, 114 illustrations and two color plates and is priced at \$6.50.

PRACTICAL MALARIA CONTROL—A Handbook for Field Workers—Carl E. M. Gunther, M.D., D.S., D.T.M. (Sidney), Field Medical Officer of Bulolo Gold Dredging Limited, Territory of New Guinea at present with the Australian Medical Corps. Published by the Philosophical Library of 15 East 40th Street, New York, the little book of 91 pages is priced at \$2.50.

HANDBOOK OF NUTRITION—A Symposium (Prepared under the Auspices of the Council on Foods and Nutrition of the American Medical Association), and published by the American Medical Association of 535 North Dearborn Street, Chicago 10, Illinois. The book of 586 pages, priced at \$2.50, contains the latest literature on proteins, carbohydrates, fats, mineral salts and vitamins, and has briefs from leading authorities on nutrition in the United States. A good buy for every doctor's library.

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Second Dist. Council	Margaret Provost, Strong City
Third Dist. Councilor	Mary Nicholson, Winfield
Fourth Dist. Councilor	Adena Miller, Ellsworth
Fifth Dist. Councilor	Lois Clopper, Dodge City

ANNOUNCEMENT

The Council and Executive officers of the Kansas Medical Assistants' Society will hold a meeting in Kansas City on September 3, 1944, at 10:00 a.m., with the place of meeting to be announced later, according to word received in the office from Dolly Harrington, of Wichita, the Secretary. Plans for the coming year, for the annual meeting, and activities of the county organizations and the state society will be discussed at this time. It is hoped that all state officers, and councilors will be present.

MEDICAL ASSISTANTS' MEETINGS

The Lyon County Medical Assistants' Society held a business meeting and dinner at the Broadview Hotel in

Emporia on July 5. Miss Claudia Williams was installed as the new president; and Mrs. Margaret Provost as the secretary-treasurer. Installation services and business meeting followed the club dinner.

The Sedgwick County Medical Assistants' Society held its annual picnic at Linwood Park in Wichita on June 16. Thirty members were present.

The newly elected officers of the Sedgwick County Medical Assistants' Society who will be installed at the December, 1944, meeting are as follows: Charlotte Parrish as president, Donna Harrison as vice-president, Catherine Dillon as secretary, and Shirley Drake as treasurer. The members of the board of directors are: Rasalee Anderson, Bernice Bounous, Helen McClain, Virginia Kaelson and Josephine Ackley.

BIRTHS, DEATHS AND MARRIAGES IN KANSAS IN 1942 AND 1943

Kansas recorded increases in births, deaths and marriages in 1943, as compared to 1942, according to figures recently compiled by Miss Minnie Fleming, State Registrar. The total births last year, 35,749, is the highest number reported in the state since 1925. Births reported in 1942 numbered 33,628. In 1925, when the previous high birth total was recorded, the Kansas population was greater by approximately 100,000 persons than it was during 1943.

There were 920 more deaths reported in the state last year than in the previous year, respective totals being 19,239 and 18,319.

The increase in marriages was not so marked, as the 1943 record was 26,074, and that of 1942 was 25,898.

It is anticipated that both marriages and births will decrease during the current year, according to national statisticians.—Kansas State Board of Health Newsletter.



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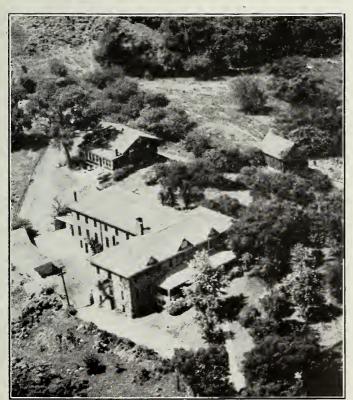
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AUXILIARY

PRESIDENT'S MESSAGE

Before this message reaches you, you will be planning your September meetings, on your way to a very successful year, I trust. Health education is so important and who is more capable of being its guardian than the physicians wife?

In September, all auxiliaries should have a membership drive and in turn each member should read the National Bulletin and become informed on the plans the National Auxiliary have asked us to accomplish. We should feel responsible for Hygeia distribution so that the public may have the correct medical information.

September 27-28, the Fall Board meeting of state officers, past state presidents, councillors, chairman of standing committees and county presidents will be held in Salina. You will be house guests of Saline County Medical Auxiliary members and of your president. We have planned a full program for you so we hope it will be possible for everyone to attend. The officers want to meet personally all fourteen county presidents so that programs and public relations plans may be discussed. It is always interesting and instructive to learn about the problems of other auxiliaries.

The Year Books will be mailed to you the latter part of August. The state chairmen will send you their plans as soon as they receive the Year Book.

Mrs. Herrick, your Parliamentarian, has a very fine article on parliamentary rules. It will be very useful in your meetings this year. Please file in your note books.

Mrs. Billingsley, State Hygeia Chairman, has written about Hygeia. I do hope you will arrange with her or your county Hygeia chairman to place as many subscriptions as possible. You may request a sample copy to be sent to any of your friends.

The Press and Publicity Chairman, Mrs. Millis, askes you to report all metings to her and send clippings for the scrap book so that all county auxiliaries will be represented on the Auxiliary page of the Journal of the Kansas Medical Society.

Mimeographed copies of the Auxiliary page are being mailed to you so if the Journal remains in the doctor's office, you may still read the instructions and suggestions from your state officers.

I hope you have had a nice vacation and will have stored up extra pep for the auxiliary program.—Mrs. Leo J. Schaefer.

KNOW PARLIAMENTARY PROCEDURE*

PRESIDENT'S VOTING PRIVILEGE—One of the questions most frequently asked is: "Does the president (or presiding officer) vote?"

The president (or presiding officer) does not vote in a "voice vote" except to break a tie.

In a voice vote in case of a tie, the president may do one of three things, as follows (called casting vote):

- A. She may vote with the affirmative, and the motion is carried.
- B. She may vote with the negative, and the motion is lost.
- C. Or she may say: "The Chair not voting, the motion is lost."

In a ballot vote, the president votes as any other member in good standing. She votes as a member, not as an officer, and votes, of course, before the votes are counted. If there is a tie in a ballot vote, the vote must be taken again.

THINGS TO REMEMBER IN PARLIAMENTARY PROCEDURE—There are three ways of bringing business

before an organization:

I. By communication (letter or petition).

2. By resolution (a motion to adopt is necessary).3. By motion (there are 30 different motions in Parlia-

mentary Procedure).

There is a resolution for every problem and question that arises in organization work in the correct use of these 30 motions.

There are six steps necessary in the making of a motion:

- I. Recognition by the Chair. Always address the Chair. "Madam President . . ." and be recognized before speaking. (No member has the privilege of the floor until given by the Chair.)
 - 2. Statement of the motion. "I move . . ."

3. Second to the motion.

- 4. Statement by the Chair. "It has been moved by Mrs. Blank and seconded that . . ."
- 5. Discussion. (Every member has the right to debate on debatable motions.)
- 6. Vote. In taking the vote the Chair says. "All those in favor of . . . say 'aye'. Those opposed say 'no'."

There are six things to know about every motion:

1. Object. (What is the purpose to be accomplished by the motion?)

2. Form. (How do you state it?)

- 3. Rank. (When is the motion in order?)
- 4. Debatable. (Can you discuss it?)
- 5. Amendable. (Can you change it?)
- 6. Vote. (Does it take majority or two-thirds vote?)

SOME DEFINITIONS

- I. Majority Vote—Anything over half of those present and voting.
 - 2. Plurality Vote-Highest number.
 - 3. Tie Vote-Same number for and against.
 - 4. Unanimous Vote-No one dissenting.
 - 5. Voice Vote-"Ayes" and "nays."
- 6. Standing Vote—Counted vote (anyone may call for a "division").
 - 7. Ballot Vote-Secret vote.
- 8. Roll Call Vote—Voice vote by calling roll of members.
- 9. Proxy Vote—Vote cast for another by authority given (allowed only in incorporated groups or by By Laws).
- 10. Instructing the Secretary—Not considered good procedure.
- 11. Quorum—Least number that can transact business. (Quorum should be stated in By Laws. If a definite number is not given the quorum is a majority of entire membership.)
 - 12. Quorum of a Committee—A majority of committee.
- 13. Ex-Officio—An ex-officio member of a committee is a member who is so designateed in the By Laws, by virtue of her office (usually the president). She has every privilege (the right to discuss, to make motions, and to vote), but she is NOT counted in the quorum of the committee.
- 14. Parliamentarian—A Parliamentarian gives advice to the president. The president makes the rulings.—Mrs. W. Y. Herrick, Wakeeney.

^{*} Presidents: Keep this article before you for ready reference as you preside.

THE JOURNAL

of the

KANSAS MEDICAL SOCIETY

Owned and Published by The Kansas Medical Society

Volume XLV

SEPTEMBER, 1944

Number 9

NEWER ASPECTS IN THE MANAGEMENT OF HYPERTENSION*

Edward Massie, M. D.

St. Louis, Mo.

When one considers the serious complications of hypertension and its extremely widespread character, it is easy to realize that there is more than adequate stimulus for search for improved treatment of this devastating disease. Yet up to the present time, a successful, practical, and safe procedure for the routine treatment of essential hypertension has not been devised. On the other hand, the pathogenesis of arterial hypertension so far the underlying physiologic and morphologic precesses are concerned is fairly well established. The relation of certain types of arterial hypertension to renal ischemia has been demonstrated through experimentation.1 Evidence is at hand to suggest that humoral agents of renal origin cause hypertension but intense investigation has not yet succeeded in revealing the true nature of the mechanism operating between renal ischemia and hypertension. Recently important evidence is presented suggesting that essential hypertenson is a general symptom which may be caused not only by renal but also by vasomotor factors.2 Spinal anesthesia which has little effect on the blood pressure of normal people may produce a profound and sudden fall in the blood pressure of patients with essential hypertension. When the local anesthetic action has worn off, the blood pressure of hypertensive patients returns in a few minutes to the usual level for those patients. This rapidity of action points to a nervous mechanism and strongly suggests that essential hypertension may apparently have a vasomotor cause of central nervous origin as well as possible humoral cause involving the kidneys.

Recently the subject of hypertension in military service has provoked a problem which is rapidly becoming of considerable importance to the civilian

*From the Department of Medicine, Washington University School of Medicine, St. Louis, Missouri. Presented at the annual meeting of the Kansas Medical Society, in Topeka, May 10, 1944. physician as more and more young men are rejected for induction into the armed services because of borderline or actual hypertensive disease. There are many men who have become anxious over the present significance or future consequence of the finding of an elevated blood pressure by military medical examiners. Most of these men feel that they would not have been rejected or discharged from the armed services if they had not had a serious degree of hypertensive disease. Actually, the majority of such men would be classed more correctly as "vascular hyperreactors", and the question of when or whether they will have serious hypertensive disease is left unanswered at this time. A number of the candidates, however, with borderline hypertension have been accepted for active duty in the armed services. Instances in which this condition has led to the development of clinical symptoms and unfitness during active naval campaigns has recently been reported by Master.3 At first thought, it would appear that the ideal solution to the problem of selection would be to reject all persons presenting hypertensive levels at any one reading. When statistical figures are considered, however, the incidence of hypertension in the general population would be so high as to prevent the attainment of the minimum goal required for the armed services. In addition, it is quite probable that a large number of men who are being rejected for this reason might not have significant or disabling disease for years.

Considering the implications of this difficult problem, Master suggests that a different approach be adopted. The question of fitness for active duty in the borderline cases is not so much dependent on the height and variability of the blood pressure as on the absence or presence of complications of hypertension. An uncomplicated mild hypertension is compatible with a high degree of physical activity and need not be a cause for rejection. A complete cardiovascular examination including a roentgenogram of the chest, electrocardiograms, exercise tests, examination of the retinal vessels, and renal function studies are necessary in order to determine the presence of cardiac enlargement, myocardial damage, coronary disease, arteriolar lesions, and renal insuf-

ficiency. On these criteria and not on blood pressure measurements alone should the physician base his judgment as to the suitability of candidates for military service, or for analogous activities in civilian life.

GENERAL MEASURES

The true refractory nature of hypertension to treatment is confirmed by the large number of medical and surgical techniques which continue to appear in the literature. Any disease which can be controlled by appropriate therapy, characteristically does not require such a wide variety of therapeutic measures as are now proposed for hypertension, not only in the advertising appeals of manufacturers, but also in the scientific literature. It is well to state at this point that the belief, which still persists in some quarters that, it is inadvisable to lower blood pressure in the presence of essential hypertension has no foundation in fact. In uncomplicated hypertension, vital functions continue normally when blood pressure is reduced, and not only is the reduction of blood pressure in itself not harmful, but it very frequently is highly desirable. There are certain therapeutic measures which are universally accepted and which must always be advised before consideration of any more specific steps. Proper rest, and reduction of nervous stresses and strains are always indicated as are frequent vacations and the acquiring of a calm philosophic outlook on life. Individuals who are overweight should reduce but aside from a reduction diet there is very little evidence that any special food, either by its inclusion or exclusion from the diet, will influence blood pressure. Restriction of moderate use of alcohol and coffee is not imperative unless their use results in abnormal stimulation. Smoking may increase the blood pressure of patients who have hypertension, and if this can be demonstrated by having the patient smoke after his blood pressure has reached a basal value, it is advisable to consider sharp restriction or complete elimination of the habit.

There is a great deal of legitimate skepticism concerning the value of the medical treatment of hypertension. One drug after another has been proposed and many of them have been reported as giving complete or partial symptomatic relief with or without a more or less marked reduction in blood pressure. Experience has shown, however, that practically all these medications exert no specific benefit. Vasodilators regardless of the variety are not effective. Sedatives are universally used and are indicated to help bring about nervous relaxation during the daytime and adequate sleep at night.

THIOCYANATE THERAPY

At the present time, the most useful of the so-

called specific remedies for the lowering of blood pressure and the relief of symptoms in the hypertensive patient is sodium or potassium thiocyanate (sulfocyanate). It should be stated, however, that symptoms associated with essential hypertension may be relieved by mental suggestion inherent in any seriously or enthusiastically prescribed method of treatment.4 In an investigation of the effect of thiocyanate several years ago, the author^{5 6} attempted to eliminate these psychotherapeutic effects as completely as possible. During an initial control period of three months without specific treatment of any kind, a number of subjects known to have hypertension from previous observation were closely studied to establish the usual levels of the blood pressure and to determine the ordinary complaints. Under similar conditions of observation and without any attitude of suggestion or enthusiasm, there followed in succession a period of therapy with thiocyanate in a disguising vehicle and a second control period during which the patients believed they were still under active treatment although they were given only the vehicle and not the active drug. In the majority of cases, during the period of active therapy, there was an appreciable drop in blood pressure with an average fall of systolic pressures ranging in the various patients from sixty-six to twenty-one mm. and an average fall in diastolic pressures varying from thirty-three to eight mm. In contrast to these average values, the maximum fall in blood pressures of from eighty to thirty-seven mm. systolic and fortysix to eighteen mm. diastolic was more striking. It seems particularly impressive that in the second control period when the active drug was surreptitiously omitted and only the vehicle was given, the original complaints recurred and blood pressures gradually rose to approximate those of the initial control period. The effect of thiocyanate therapy on blood pressure is well illustrated in Fig. 1.

The principal symptoms attributable to hypertension, such as persistent and troublesome headache, marked nervousness, and mild vertigo, either decreased appreciably or disappeared entirely under treatment. Many of the patients felt that they were definitely improved while receiving thiocyanate. The symptom most affected by the drug was headache or a sense of cephalic fulness. In most cases this complaint was either banished or occurred with less frequency or intensity. A striking sedative effect was also experienced by some of the patients and vertigo and nervousness were frequently well controlled. Insomnia was often relieved, and unusual activity, excitement and emotional upsets were well borne. Occasionally the cardiac symptoms of dyspnea and heart consciousness were improved. Subsequent study of a large number of cases in the past several

years for the most part has substantiated the results of the previous investigation. It appears that over half of the patients so treated have a good objective and subjective response to the drug. Other investigators have obtained similar results.

Thiocyanate may be used for ambulatory patients and can be administered either as the sodium or the potassium salt since the effective constituent is the cyanate ion. It is best given as a five per cent solution in various vehicles of which aromatic elixir and elixir phenobarbital are quite satisfactory. In this dilution, four cc contains the unit dose of 0.2 gram of the drug. The routine used to initiate thiocyanate treatment is to give three daily doses of 0.2 gram for the first five or six days and then twice daily for a similar period. In each instance, initial and maintenance doses must be determined according to the level of blood cyanate and all doses adjusted from time to time as considered necessary. The usual maintenance dosage ranges from 0.2 to 0.4 gram daily. Usually for proper control, the patient must be seen at least every two to three weeks, although a monthly interval between appointments may be satisfactory in those in whom previous experience has revealed a very constant blood level. At each visit the patient should be questioned carefully in regard to the occurrence of any toxic symptoms. A routine urine examination and blood nonprotein-nitrogen determination on the average of once monthly is desirable since many of the patients have coincidental renal disease. The optimal blood

level is eight to twelve mg per cent, for at this range patients experience the most beneficial therapeutic effects with the fewest difficulties. It is a good rule to maintain the blood-cyanate concentration at the lowest possible level consistent with a good therapeutic result. The usual medications may be given along with thiocyanate without fear of incompatibility, although if sulfonamides are indicated it is best to discontinue thiocyanate temporarily.

Minor toxic symptoms often occur during the first two to four weeks of therapy and consist principally of weakness, aches in the legs, slight epigastric distress, nausea, mild dermatitis, and occasional decreased libido. Rarely, marked nervousness may be manifested. The most frequently encount-

ered symptom, however, is the sensation of weakness and excessive fatigue. Usually it is slight or moderate and does not interfere with treatment. More often it occurs early and disappears after the first few weeks of therapy. Infrequently it is severe enough to necessitate stopping therapy and as a rule in such cases the blood-cyanate level will have been maintained at a high range in an effort to reduce an unusually high and resistant blood pressure. More serious complications mentioned in the literature consist of such difficulties as angina pectoris,5 exfoliative dermatitis,78 congestive heart failure, cerebral thrombosis, and psychosis.9 In my own experience, except for the occurrence of angina pectoris, these more serious occurrences have not been encountered. Usually they can be avoided or anticipated by close scrutiny and control of the patient on his frequent visits, but since some of the incidents tend to occur in the course of the fundamental disease, it is not always easy to identify the exact cause of the complication. A simple dermatitis during therapy may be a forerunner of an exfoliative dermatitis and thus deserves close attention. The occurrence of angina pectoris is very infrequent and in my experience is coincident with a marked fall in blood pressure, usually in an elderly patient with moderate to marked arteriosclerosis. In such cases the attacks of precordial pain tend to disappear when the blood cyanate level is allowed to fall and the blood pressure permitted to rise to a more moderate range. It seems not unlikely that angina pectoris during thiocyanate

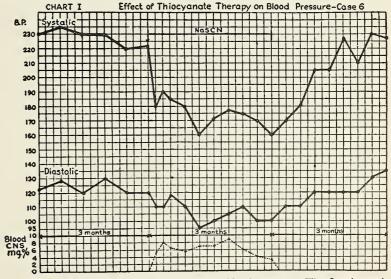


Fig. 1. Effect of thiocyanate therapy on blood pressure. The first interval of three months represents the initial control period, when no medication or treatment was given. The second three months shows the results obtained during the therapeutic period when sodium thiocyanate was given in a flavored vehicle. The final three months represents the second control period during which the vehicle alone was given, the active medication having been omitted without the patient's knowledge.

administration occurs as a result of excessive lowering of blood pressure and subsequent circulatory insufficiency. In cases of prolonged thiocyanate administration, loss of weight and a moderate anemia have been said to occur as has the occasional development of a cabbage goiter.

Thiocyanate therapy, generally speaking, should be restricted to cases of uncomplicated vascular hypertension in patients not usually over sixty years of age and without marked arteriosclerosis. It is apparent that most of the severe complications with the medication occur in those who do not conform to this restriction. Patients should have satisfactory cardiac function or at least should give no evidence of angina pectoris or cardiac decompensation. Renal studies should show fairly normal function; at least the blood non-protein-nitrogen should be within normal limits. Albuminuria is no contraindication. Preferably there should be no history or physical signs of a cerebral vascular accident in the recent past. In addition, the patient must be cooperative and sufficiently intelligent to be cognizant of early toxic symptoms.

UNILATERAL NEPHRECTOMY

A new approach to the treatment of hypertension in selected cases was gained as a result of Goldblatt's demonstration of the production of hypertension by clamping of the renal arteries and the publication of several excellent papers pointing out the role of pyelonephritis in the pathogenesis of hypertension. 10 11 Many articles have appeared in the literature concerning the more recent form of treatment of hypertension by unilateral nephrectomy. Actually hypertension in unilateral renal disease is less common than generally thought. Braasch, Walters and Hammer¹² observed hypertension in only 18.4 per cent of 1,684 patients who were subjected to renal surgical procedures of all types. Judging from the cases reported in the literature the most frequent pathologic condition found in the kidneys removed for hypertension is chronic pyelonephritis.

In any case in which unilateral renal disease is suspected and in which nephrectomy is contemplated, it is of the utmost importance to appraise carefully the functional status of both kidneys. This is especially true if hypertension exists, for the removal of one kidney, if it retains any function at all, will place an increased load on the remaining organ which if its function is but slightly impaired will result in relative or functional ischemia of that organ. The result is that there will be no beneficial change in the blood pressure. The diseased kidney should be functionless or practically so before its removal can be expected to alter the blood pressure significantly. The opposite kidney, on the other

hand, must be functioning normally so far as its function can be measured by means of pyelography and by recognized clinical tests of renal function. Careful bacteriologic study of the urine from the normal kidney must be made before one can be certain of the absence of infection. The evaluation of renal function, unfortunately is at times extremely difficult, and this makes the problem all the more complicated. The following criteria suggested by Sensenbach¹³ for the selection of patients with hypertension for whom nephrectomy is indicated, should be carefully met if success is likely to be attained.

- 1. The diseased kidney should be functionless or its function greatly diminished.
- 2. The opposite kidney should function normally.
- 3. The hypertension should be of short duration.
- 4. Other factors being equal, the younger the patient, the greater the chances of favorable results following nephrectomy.

RENAL EXTRACTS

The hope of successful therapy by renal extracts has not materialized. The announcement of this advance in treatment was made by Grollman, Williams and Harrison¹⁴ and by Page.¹⁵ The possibility of developing this therapeutic method for reducing high blood pressure rests upon the discovery that in the kidneys of animals and man a substance called renin is produced. This substance combining in the blood stream with a chemical designated as an activator, produces a third substance which has pressor action and has been named angiotonin. The kidney also produces a substance which apparently counteracts angiotonin lowering blood pressure in hypertensive animals. When a kidney becomes disabled, however, its secretion of renin is believed to overbalance the secretion of this inhibitor of hypertension. As a consequence the excess of renin leads to the production of an excessive amount of angiotonin which subsequently raises blood pressure. This observation led to the preparation of kidney extracts which appear to produce their anti-pressor action at least partly through their ability to neutralize angiotonin. These extracts have held considerable promise but a successful result has not yet been realized. Page¹⁵ reported the use of kidney extracts in a series of thirty-seven patients, twenty-four of whom had malignant hypertension and thirteen essential hypertension. Nine of the former died, six in uremia, and three of cerebral hemorrhage, whereas, none of the cases of essential hypertension resulted in a fatality. The most striking changes following treatment were reversal of eyeground abnormalities with improvement in vision, increase in cardiac output, and decrease in diastolic blood pressure. Unfortunately, because of occasional shock-like reactions, the lack of standard chemical procedures to yield a uniform product of high potency, and the great difficulty of their preparation, renal extracts cannot at present be regarded as a practical means of therapy. Although in some cases the objective signs and subjective symptoms have been improved, in general the results with the kidney extracts appear to be inconclusive and this form of therapy must still be considered as an experiment of great interest, but one which must be pursued much further before it can be proposed as a treatment in the true sense of the word.

TYROSINASE

Following the suggestions that hypertension might be due to a pressor amine released by ischemic kidneys, Schroeder and Adams¹⁶ investigated the effect of a specific oxidative enzyme capable of altering pressor amines. The enzyme, tyrosinase, isolated from mushrooms, was found to lower consistently the blood pressure of hypertensive rats and dogs when given intravenously. Subsequently, tyrosinase was administered to seventeen patients suffering from arterial hypertension by daily subcutaneous injections for periods of three to four weeks.¹⁷ Of fourteen cases who previous had systolic pressures above 200 and diastolic above 120 mm., significant decreases of pressure were obtained in thirteen. In addition, definite symptomatic improvement occurred. When tyrosinase administration was discontined, the blood pressure soon returned to its previous level, but symptomatic improvement continued to last for several weeks or months. The injections were painful and caused frequent reactions. That the blood pressure lowering effect of tyrosinase is due to enzymatic activity is questionable in view of the more recent observations that heat inactivated tyrosinase preparations are as effective as active ones in reducing blood pressures in patients with hypertension.18 It has been suggested that the effects and reactions obtained with tyrosinase resemble those which may be expected after injection of a non-specific protein material, and it seems possible that such effects and the therapeutic results so far observed are closely related. Further investigation with this type of therapy is warranted, but it must be considered only experimental at present.

FISH OILS

Vitamin A in large doses has been recommended in the treatment of hypertension¹⁹ but more careful observations have shown that it is relatively inert.²⁰ Grollman and Harrison have demonstrated that the agent responsible for the observed reduction in blood pressure in their reports is not derived from vitamin

A but resides in some other constituent of fish oils which happens to be concentrated in commercial preparations of vitamin A. Preliminary studies demonstrate surprising similarities between fish oils and kidney extracts as regards their general physical and chemical properties. They are almost identical insofar as their effect on the blood pressure is concerned. The relatively high potency and ready availability of crude fish oils render these more satisfactory than kidney as a source of the active principle effective in hypertension. As yet, there is no clinical experience with the use of fish oils, but since the antihypertensive substance contained in them is effective by mouth and apparently in small amounts, further work leading to its production and identification is highly desirable and should be reported in the very near future.

SURGICAL TREATMENT OF HYPERTENSION

Sympathectomy by one method or another has been performed in the past eighteen years in about 3,000 cases. The literature, however, indicates widely varying opinions concerning the effects of different operations on the levels of blood pressure and the course of the disease. The techniques more commonly used include the supradiaphragmatic bilateral splanchnicectomy described by Peet,21 the subdiaphragmatic splanchnicectomy with lumbar ganglionectomy descried by Allen and Adson²² who in some cases also added a partial adrenalectomy, and Smithwick's23 operation which consists of a two-stage bilateral transdiaphragmatic procedure in which are removed the entire great splanchnic nerves, their aortic branches, and the sympathetic ganglions the ninth, tenth, eleventh and twelfth dorsal ganglions, the first lumbar and occasionally the second lumbar ganglions.

From the point of view of the internist, the results up to the present have not been very encouraging and seemed to suggest that this radical form of therapy should still be considered in the experimental stage. In a comparative study by Flaxman²⁴ of the mortality statistics of 244 hypertensive patients observed by himself and treated only medically, with the mortality of 350 hypertensive patients treated surgically with supradiaphragmatic splanchnicetomy by Peet and his co-workers, very little difference was noted between the two groups. Flaxman concluded that it is doubtful whether so-called specific surgery alters the course and prognosis in cases of hypertension, including those with malignant hypertension. In a report from the Johns Hopkins Hospital on the subject of sympathectomy in essential hypertension,25 of twelve patients who had been primarily selected because of their incapacitating symptoms, only five had a lowering of arterial pressure which lasted for six to eighteen months while nine noted relief from symptoms referable to hypertension. In only two patients did the abnormal findings in the heart and eyegrounds regress during the period of lowered arterial pressure. These authors felt that sufficient time had not elapsed to state with certainty that the course of the disease was altered by operative intervention. The surgical procedures used in this series included both the supradiaphragmatic and the infradiaphragmatic types of splanchnicectomy.

Recently, however, Ayman and Goldshine²⁶ have suggested that surgical therapy in hypertension may be quite effective judging from a carefully handled investigation in which they reported a late follow-up study of thirteen patients who had undergone a variety of sympathectomy denervations and who had been subjected to unusually detailed controlled study which in some cases persisted over a three to five year period after operation. They felt that their data pointed fairly strongly to the conclusion that sympathectomy regardless of its rationale is one of the most successful forms of therapy in essential hypertension in producing a marked non-toxic lowering of the blood pressure. They specifically state that no medical therapy has ever equaled the results obtained in five of the thirteen cases. They also contend that no one can point to a single well controlled patient in which medical treatment has brought the size of the heart, the electrocardiogram, and the blood pressure back to normal as has been accomplished by sympathectomy in some of the cases of their series. In addition, the symptoms improve and the patient's incapacity becomes replaced by normal activity lasting at least as long as five years. Eight of their cases responded successfully. So-called Group IV patients with extensive and rapidly progressive arteriolar disease persistently did not respond. Success in general was more constant in those patients subjected to extensive denervation. The transdiaphragmatic type of splanchnicetomy with dorsolumbar ganglionectomy performed by Smithwick was the most effective type of operation. Judging from these results it would appear that therapy by sympathectomy preferably by the Smithwick procedure should be strongly considered in patients with essential hypertension in whom progressive elevation of blood pressure is found after long and careful study or in whom evidence of beginning vascular damage is demonstrated.

SUMMARY

The treatment of essential hypertension remains one of the unsatisfactory chapters in therapeutics. The fundamental causes of essential hypertension are for the most part still obscure and we can neither remove

or successfully combat them. In many instances no methods at our disposal will serve to lower the blood pressure for any significant length of time. In other instances the blood pressure can be reduced for a longer period with beneficial effect. The treatment is still symptomatic rather than ideally etiologic. Yet one cannot assume too pessimistic an attitude for there can be no doubt that in many cases much can be done for the patient in controlling the manifestations of the disease and in combating its compli-

There is as yet no specific treatment in essential hypertension. Thiocyanate therapy continues to enjoy considerable favor despite occasional untoward effects. Further experience with extracts of kidney tissue has yielded somewhat disappointing results. A substance contained in fish oils appears to have an anti-hypertensive effect and further study in this field is indicated. The use of tyrosinase, an enzyme specific in altering phenolic compounds has been shown to lower blood pressure but apparently not by its enzymatic action; continued investigation with this material is warranted. In very selected cases, unilateral nephrectomy results in an occasional dramatic response. The most consistently good results appear to have been obtained following surgical therapy in properly selected cases with use of the newer technic of two-stage bilateral transdiaphragmatic splanchnicectomy with sympathectic ganglionectomy described by Smithwick.

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CHRONIC CYSTIC MASTITIS A THERAPEUTIC PROBLEM

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One may approach the treatment of chronic cystic mastitis with the easy philosophy that the total removal of mammary tissue will for all time relieve the patient of worry and risk and the surgeon of responsibility. However, it is assumed as basic that the preservation of the breast from the functional, the cosmetic, and the psychological standpoint is both desirable and commendable if it can be accomplished with reasonable safety to the patient. In addition to surgery there are the more conservative methods of x-ray and endocrine therapy.

Three states of chronic cystic mastitis are recognized. These are the painful breast, adenosis, and cystic disease.

ENDOCRINE THERAPY

The Painful Breast: The painful breast, or mastodynia, is a frequent precursor of the lesion that may develop into chronic cystic mastitis. Mammary pain and tenderness, which at first is slight and premenstrual, becomes more severe and finally lasts throughout the menstrual cycle. Regression may spontaneously occur, but more frequently adenosis or cystic disease may supervene.

Endocrine therapy for mastodynia has been recommended by Lewis and Geschickter¹, Cutler², and others. Lewis and Geschickter report definite relief by the intramuscular administration of 10,000 international units of estrogenic substance twice weekly for the first two months, twice monthly for the next two months, and once monthly before each menstrual period until a total of six months has elapsed. Cutler recommends the use of whole ovarian residue in doses of five grains three times daily for ten days before each menstrual period for a total time of six months.

Adenosis: Adenosis, or the so-called "shotty breast," is characterized by epithelial proliferation resulting in small intracystic papillomas or nonencapsulated adenomas. The essential dysfunction is apparently in the pituitary gland causing irregularities in the secretion of ovarian hormones. Estrogenic therapy here suppresses pituitary activity and allows breast changes to be carried forward to a state of involution or fibrosis. The schedule of endocrine therapy for the painful breast is also applicable to adenosis. Testosterone propionate is considered of therapeutic value in preventing the ovarian follicle from ripening which in turn suppresses the secretion of gonadotrophic hormone from the pituitary, thus correcting pituitary dysfunction. Loeser³ and Spence⁴ report favorable results from the intramuscular administration of twenty-five to 100 mgms. of testosterone propionate twice weekly for a period of six months. They warn that masculinizing sideeffects may result from this hormone and advise that it be administered under careful observation.

Cystic Disease: Increased connective tissue, epithelial involution, and accelerated secretory activity of the cells of the terminal breast tubules with cystic formation characterize the pathological picture of cystic disease. Estrogenic therapy inhibits secretory activity and encourages fibrosis by suppressing excessive pituitary function. The sudden stopping of therapy, the continuing of therapy over too long a period of time, or the administering of over 20,000 international units of estrogenic substance weekly may reverse the process and cause cysts to reappear. Lewis and Geschickter¹ recommend 10,000 units of estrogenic substance intramuscularly twice during the first month and once monthly thereafter until a period of six months has elapsed. Testosterone propionate has failed to yield encouraging results in cystic disease, according to these investigators.

Chronic cystic mastitis is shown clinically to undergo marked regression or to actually disappear during pregnancy. Rats in which pseudopregnancy is induced by injections of goadotrophic principle from pregnancy urine do not develop cysts of the breast on large, repeated doses of estrogenic substance. Both of these observations substantiate the fact that proper endocrine therapy may be effective in chronic cystic mastitis.

X-RAY THERAPY

X-ray therapy to the mammary glands in chronic cystic mastitis has failed to yield encouraging results in the hands of most clinicians. Reynolds⁵, however, reports successful treatment of the condition by small doses of long wave-length rays at eighty kilovolts. He ascribes the favorable results as being due to the increased lymph flow which relieves the lymph stasis thought to be a factor in causing the proliferative activity of ductal and acinar epithelium. Taylor⁶, observing the improvement of chronic cystic mastitis following the cessation of menses, reports the relief of symptoms by a single, nonsterilizing, high voltage dose of 200 Roentgen units to the ovaries.

SURGICAL THERAPY

Whether or not chronic cystic mastitis is regarded as a precancerous lesion will influence the extent and type of surgical therapy.

Painful Breast: Less radical measures than surgery are usually successful in the treatment of the painful breast. At times, however, persistent pain may require the submammary injection of novocaine or the alcoholic injection of the third, fourth, and fifth intercostal nerves. Intractable breast pain may necessitate mastectomy.

Adenosis and Cystic Disease: The divided opinion as to whether chronic cystic mastitis is or is not a precancerous lesion has caused two groups to develop.

One group, composed of such investigators as Greenwood⁷, Lewis and Geschickter¹A, Harvey⁸, and Rankin and Grimes⁹, do not consider chronic cystic mastitis as precancerous. This group believes that the "shorty breast" of adenosis should receive endocrine therapy and that any localized areas of tumefaction should be removed by biopsy study. If the study shows a benign state the remainer of the breast should not be disturbed. They advise the excision of large single cysts of cystic disease. They believe tht multiple small cysts of cystic disease should receive endocrine therapy and that such conditions do not usually warrant extensive surgical procedures.

The other group, composed of such investigators as Cahill and Caulfield¹⁰, Warren¹¹ and Pressly¹², accept the statement of Cheatle and Cutler¹³ that carcinoma is associated with chronic cystic mastitis in twenty per cent of cases, and believe that breasts involved by adenosis or cystic disease should be subjected to simple mastectomy.

The treatment of chronic cystic mastitis will continue to be a problem until pathologists agree on what constitutes a precancerous lesion of the breast. The decision as to proper treatment rests with the clinician, and of paramount consideration is the welfare of the patient. The therapeutic problem involved is the simultaneous avoidance of dangerous conservativism and unnecessary radical surgery.

SUMMARY AND CONCLUSION

- 1. Three states of chronic cystic mastitis are recognized: the painful breast, adenosis, and cystic disease.
- 2. Three recognized types of therapy for chronic cystic mastitis are endocrine, x-ray, and surgery.

3. Endocrine therapy:

a. The painful breast:

10,000 units of estrogenic substance intramuscularly twice weekly for the first two months, twice monthly for the next two months, and once monthly until a total time of six months has elapsed.

b. Adenosis:

Estrogenic therapy as in the painful breast.

Testosterone propionate in doses of twenty-five to 100 mgms, twice weekly for a period of six months has yielded favorable results.

c. Cystic disease:

10,000 units of estrogenic substance intramuscularly twice during the first month and once monthly until a period of six months has elapsed.

4. X-ray therapy:

X-ray therapy is of questionable value in all three forms of chronic cystic mastitis.

5. Surgical therapy:

Surgical therapy will be largely controlled by whether or not chronic cystic mastitis is regarded as a precancerous lesion. The conservative group advises excision of suspicious areas for biopsy study. The radical group advises simple mastectomy for adenosis or cystic disease.

6. The problem of therapy in chronic cystic mastitis will be largely clarified when pathologists agree on what constitutes a precancerous lesion of the breast.

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(Continued on Page 316)

President's Page

To the Member of The Kansas Medical Society:

Your Committee on Postgraduate Education Fund has completed its preliminary work and you will soon hear from its chairman, Dr. Harold H. Jones.

The plan is to raise \$100,000 among the doctors and friends of medicine to supply post-war graduate training at the University of Kansas, for the members of our profession who have been serving in the armed forces. The course also will be open to civilian physicians after the needs of our armed forces are cared for.

We hope you will all make liberal contributions to this fund. Our government respects gifts to scientific organizations by making those contributions deductible from your income tax. We are all most anxious to begin this program before the return of our doctors serving with the armed forces. The time to prepare is now.

Sincerely,

M. Trueheart. M. D.

President, the Kansas Medical Society

EDITORIALS

MEDICAL MEETING

The Kansas doctors of medicine who keep abreast of the progress of medicine, surgery, and the specialties, will have a busy time from October 2nd through October 27th. The Kansas City Southwest Clinical Society has scheduled its 22nd annual clinic for October 2, 3, and 4th in Kansas City and an unusually outstanding group of speakers have been secured. The program for their meeting will be found on page 321 of this issue of the Journal.

The Oklahoma City Clinical Society will be held October 23, 24, 25, and 26th and Dr. Herman Louis Kretchmer, acting president of the American Medical Association, is included on their guest speaker list, which will be found on page 319 of this Journal.

For the members of the Society who live in the northern part of Kansas the Omaha Mid-West Clinical Society has announced that their twelfth annual meeting will be held on October 23, 24, 25, 26, and 27 at the Hotel Paxton and their guest speakers for that meeting are as follows: Dr. Carl E. Badgley, of Ann Arbour; Dr. Thomas Finley, of New Orleans; Dr. Paul Holinger, of Chicago; Dr. Alson R. Kilgore, of San Francisco; Dr. C. Guy Lane, of Boston; Dr. Nolan D. C. Lewis, of New York; Dr. L. R. Sante, of St. Louis; Dr. Clifford B. Lull, of Philadelphia; Major A. C. Sabin, of Princeton; Lt. Col. J. B. Brown, of Phoenixville, Pa.; and Dr. E. H. Rynearson, of Rochester.

The increasingly large number of doctors of medicine attending this tpe of assembly in the last few years in indicative of the belief that we have always held for the profession as a whole. Given interesting worth while meeting, outstanding men in their field as speakers, a program of varying interests on pertinent scienticfic subjects and the majority of the profession has an insatiable desire for increasing its fund of medical knowledge. All three of these outstanding meetings will be well attended and Kansas members will be much in evidence. The thirst for knowledge so much in evidence will be increased by our men in service who are even now returning home.

TENDERS RESIGNATION

Mrs. Mateel Todd is well known to all Kansas doctors who have attended the annual meetings for the past five years, to all who have visited the central office and to those who have had contact with

the Journal. It is with a sincere regret that we announce her departure to enter a new field in California. Her period of service has been marked by a definite improvement in the quality and appearance of the Journal as well as in its material prosperity. The Journal as well as numerous members of the profession in Kansas wish her every success.

FIVE YEARS ON THE JOURNAL

It has been a most interesting five years since the board employed me to work on the Journal of the Kansas Medical Society. Recently my resignation was tendered to the board and today before the last Journal is made up let me do a bit of reminiscing for you on my experiences in the central office.

If you will remember, your Jounral of 1938 was bound in a pale green cover which faded frequently and varied with every few issues of stock purchased by the printers. In 1941 the board changed the cover to white and purchased its own stock, a much better quality, which policy it has continued. January, 1942, saw the Journal blossom out in an originally designed cover in keeping with the modern printing trends. The April Journal this year was the largest, in number of pages, ever printed in one issue. This issue, the September, 1944 Journal, will carry the largest number of paid advertising pages ever recorded. In comparison with the same issue in 1938 which ran 20 advertising pages, this issue has 30 pages of advertising, a 50 per cent increase in six years.

The Journal of five years ago carried sections on EENT, Cancer Control, and Medical Economics, but today these appear less frequently, having been replaced to some extent by the sections on Medical School, the Auxiliary (written and edited by its own officers each month) and the new Executive Officers section which is well worth watching as the writings of Oliver Ebel, our new executive secretary, are rated at the top in medical and lay fields. The Men-in-Service section which originated as a short column has grown to suprising proportions and has elicited considerable comment from our men overseas. The book review section has suffered due to lack of time in the Journal office and of Society members. We have always wished there were more hours in the day for scientific research when editorials were to be written.

We want to thank all the officers, councilors and committee men serving in the past five years for their very fine and prompt cooperation in sending in all Society annual reports for publication in the official proceeding sections of the Journal and hope you will

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all forgive us for our frantic warnings in regard to publication dead-lines.

In the past five years the central office has had many changes in personnel caused by marriage, removal, and death. In review we have seen the following leave or stay on with us: Joyce Ryerson, Peggy Sheafor, Jane Griggs Senate, Miriam DuMars, Rosaleigh Barney, Jane Skinner, Millie Neel and in the executive secretary's office there has been: Clarence Munns, Robert Brooks, Margaret Foster (as temporary acting executive secretary) and Oliver Ebel, our efficient new secretary.

Legislative years are always a busy time in the office. It is the job of the Journal to publish information on pending medical measures, suppress material which might ultimately be used in the legislative halls against us and our objectives, and re-print in full or brief all measures affecting the profession in the state. Many of the friends of medicine formerly in the legislature are now in military service and the January session will see a great many new faces in the state house.

We believe our editorial board will draw a sigh of relief when our voice does not call them to read final page proof on the Journal each month. That is the night that at least two members of the board lose considerable sleep, miss a ball game, or cancel some previous appointment. We wonder if any of our 2,000 readers realize how many hours our Journal board members must spend each month in order that the Journal will be delivered to their office. There are scientific articles to read, approve or reject, office correspondence, editorials to write, editing and page proof to check and all the other duties and difficulties associated with any monthly periodical. If you think your Journal is good then you can voice a word of praise to you very faithful editor, Dr. W. M. Mills, who since his appointment in 1934 (at the same time Clarence Munns was chosen for the first executive secretary of the Society) has served untiringly, unpaid, often even unthanked and unrecognized, but devoting endless precious hours in those years to make your Journal one of the outstanding state medical publications in the country.

We do not believe that there are any two men who have contributed more to the progress and success of the medical profession in Kansas than these two. They have stayed carefully in the background while others have received the laurels and acclaim and dreamed their dreams for the future of the profession and many of these dreams have become realities. Perhaps their names will not appear in any medical hall of fame, but their untiring efforts will be felt by the generation of doctors of medicine who will come to Kansas.

Assisting on the editorial board and elected at the same time was Dr. L. R. Pyle, who has held that appointment ever since. Dr. Pyle, now commander in the U.S. Navy is stationed at the Brooklyn Naval Hospital and his valuable services on the editorial board are much missed. Dr. Don Wakeman, another board member in service is a major stationed in England. Dr. Wakeman's return to his position on the board will be most welcome. Dr. Robert Stewart resigned his position on the board and is now a staff member of the Ross-Loose Clinic in Los Angeles. Dr. Stewart was well known for his medical editorials. He also did considerable lay-medical writing outside his Journal editorial work. He was succeeded by Dr. Robert Knight of the Menninger Clinic. When Dr. L. E. Eckles entered military service his place was left vacant. (Dr. Eckles is a lieutenant colonel in the Navy.) The council in 1943 appointed Dr. Ernest Decker to fill his place on the board temporarily and in 1944 elected him to a four-year term. He has been of valuable assistance in the Journal work during his time on the board and is always ready and willing to accept responsibilities.

We have greatly enjoyed working for and with the doctors of medicine in Kansas. Perhaps we will miss the contacts at the state meeting the most of all our interesting duties. There are many descriptive words we could use in parting, all elusive and unsatisfactory, when the time really comes. But "Thanks for everything."

Mateel Finch Todd, Managing Editor.

CHRONIC CYSTIC MASTITIS A THERAPEUTIC **PROBLEM**

- (Continued from Page 312)

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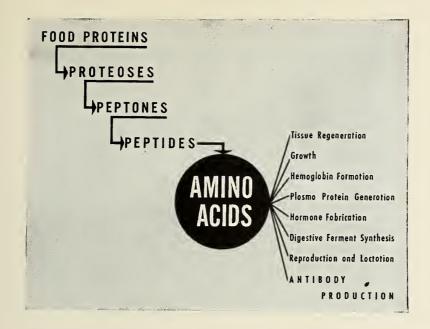
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At a recent meeting of the American Chemical Society two advances in the use of vitamin A were reported. One is the treatment of whooping cough with the vitamin, and the other is the discovery that the protein constituent enables the body to store a supply of vitamin A for emergency uses.

Dr. August B. McCoord, of the University of Rochester, and his coworkers reports that rats deficient in vitamin A have little chance of survival when inoculated with whooping cough, while those with sufficient amounts of the vitamin recover from the disease.

Study of the essential protein factor, trytophane, showed that its absence was accompanied by a low content of vitamin A stored in the liver, while the livers of animals that received the substance in their diet had a high vitamin A



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RECENT ADVANCES IN ANESTHESIOLOGY

Paul H. Lorhan, M.D.*

Kansas City, Kansas

In recent years the practice of anesthesiology has advanced so rapidly that it is impossible for the surgeon and average anesthetist to keep informed as to the progress made in the specialty of anesthesiology.

The practice of anesthesiology is constantly being affected by the introduction of new agents and technics. Furthermore, the anesthesiologist has become an important member of every operating team as evidenced by the demand for more professionally trained medical personnel.

The medical anesthetist has assumed additional duties besides his principal function as the administrator of pain obliviating agents during surgery.

The well-trained anesthesiologist is able to apply his skill towards the relief of intractable pain, furnishing valuable diagnostic test and in the favorable treatment of certain vascular and respiratory disturbances which may occur.

It is the purpose of this paper, therefore, to discuss some of the newer advances in the field of anesthesiology so that the general surgeon may become familiar with them and utilize the services of the professional anestheiologist to the best of his advantages in caring for surgical patients.

In the field of inhalation anesthesia there are volatile and gaseous anesthetics. In this branch of anesthesia there have been no important developments in recent years. Progress has, however, been made toward a better understanding of the agents used and a wider application of their uses by improvement of technic.

Ether (Diethyl Ether): Is still widely used for inhalation anesthesia. The preferred method of administering ether is by the closed carbon dioxide absorption technic. However, such equipment is not available in a majority of the smaller hospitals, so that the time-honored open-drop technic is used because of its simplicity and safety in the hands of the inexperienced. The respiratory and circulatory depression which occurs may be far from ideal; but, from the patient's point of view, its safety factor is important when no trained anesthesiologist is available. The administration of 100 per cent oxygen throughout the course of anesthesia will help greatly

to decrease the postoperative morbidity due to severe anoxia which always occurs with this form and method of anesthesia. The postoperative use of two cc. of coramine to restore muscle tonus is also advisable as well as the routine use of metrozol to combat the anesthtic depression. The maintenance of a patent airway and the postoperative use of oxygen and carbon dioxide will facilitate recovery from anesthesia and tend to prevent pulmonary complications.

Divinyl Ether (Vinethene, Divinyl Oxide): Is one of the newer volatile agents and is administered by the open-drop method for short surgical procedures and as an induction agent for ether. Divinyl ether is an excellent anesthetic for short procedures lasting up to thirty minutes. With the use of adequate doses of atropine sulphate preoperatively its ability to increase salivation is greatly decreased and the course of anesthesia is smoother. Induction time is approximately one to three minutes and the patient is usually awake within five minutes after cessation and in full control of all his faculties. Occasionally headache is a complaint, but nauseau and emesis is rarely encountered. The presence of renal or hepatic disease is a definite contraindication for its use.

Ethyl Chloride: Because of its inherent toxicity and rapidity of induction one should think twice before using this agent. It is markedly toxic to the myocardium and in the presence of an excessive adrenalin output, which will occur frequently in children, will produce during the induction stage a ventricular fibrillation from which he will not recover.

Ethyl Chloride should be used cautiously, if it must be used, and then only for a surgical procedure lasting no more than three to five minutes. The surgeon should not commence operating until the patient is in third stage surgical anesthesia and all pain reflex is abolished. Ethyl chloride should be displaced for the greater safety of divinyl ether.

Chloroform: The risks peculiar to chloroform greatly outweigh its advantages and its use is condemned. The dangers of chloroform are not only immediate but may occur as long as one month or longer after its use. For those who might persist in using it, protection should be afforded the liver by a diet of high carbohydrate and protein and a low fat content for at least three days before surgery.

The new volatile agents used are Trichlorethylene, Cyprone ether and Cypreth ether. Trichlorethylene has been used with success in the British Isles and is still confined to hospitals with well-organized departments of anesthesiology. Cyprone and cypreth ether are still in the experimental stages and offer great expectations at the present time.

The anesthesiologist has at his disposal four gaseous inhalation agents, of which three are used in the

^{*}Department of Anesthesiology, University of Kansas School of Medicine.

ANNOUNCING THE FOURTEENTH ANNUAL CONFERENCE OF THE OKLAHOMA CITY CLINICAL SOCIETY

October 23, 24, 25, 26, 1944

DISTINGUISHED GUEST SPEAKERS

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O. THERON CLAGETT, M.D., Surgery, Moyo Foundation.

CHARLES C. DENNIE, M.D., Dermotology, University of Konsos School of Medicine.

LAWRENCE P. ENGEL, M.D., Surgery, University of Konsos School of Medicine

GEORGE P. GUIBOR, M.D., Ophtholmology, Children's Memorial Hospital, Chicago, Illinois.

TINSLEY R. HARRISON, M.D., Medicine, Deon, Southwestern College of the Southwestern Medicol Foundation.

HAROLD O. JON Medicol School JONES, M.D., Gynecology, Northwestern University

RALPH A. KINSELLA, M.D., Medicine, St. Louis University School

HUGH McCULLOCH, M.D., Pediotrics, Woshington University School of Medicine.

RALPH H. MAJOR, M.D., Medicine, University of Konsos School of Medicine.

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ALAN R. MORITZ, M.D., Pothology, Horvord Medicol School.

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States and the fourth in continental Europe.

Cyclopropane: Is now widely used and is a valuable agent. It is ideal for it provides a pleasant and rapid induction. It is particularly useful as a supplementary agent in spinal and local anesthesia. Adequate relaxation may be obtained for all extraabdominal surgery and the majority of intra-abdominal cases below the umbilicus. Cyclopropane should be administered only by an experienced anesthesiologist who can properly evaulate the signs of anesthesia and correctly interpret the circulatory phenomena which frequently occur with this gas. It will frequently produce cardiac arrhythmias and they must not be regarded too lightly, especially in thyrotoxicosis. I, however, use it routinely in all hyperthyroid patients after proper premedication with the barbiturates. One cannot stress too much the importance of the use of cyclopropane only by a qualified anesthesiologist as too many patients have been sacrificed on the operating table because of the lack of knowledge on the part of the anesthetist to use this agent properly.

A sympathomimentic agent should never be used in the presence of cyclopropane anesthesia. For the patient in shock, I believe that this agent is the one of choice as I have too frequently seen patients go into marked surgical and anesthetic depression following the use of ether anesthesia.

Nitrous Oxide: Is a valuable agent in the anesthesiologist arnamentarium as it does not disturb the normal physiology of the body when used properly. Those who claim that anesthesia with this agent is produced by its asphyxial properties are ignorant of the anesthetic properties of this gas and its proper administration. Adequate oxygenation must be maintained at all times, and, if the patient has been properly premedicated with the barbiturates and morphine-scopolamine before surgery, this may be accomplished. Satisfactory nitrous oxideoxygen anesthesia requires the services of an anesthesiologist who can interpret the signs of oxygen lack or anoxia very early if a fatality is to be averted. Pelvic surgery and extra-abdominal surgery may be performed satisfactorily with this agent. If relaxation is necessary, the administration of small amounts of diethyl ether may be used. With this method, however, the nitrous oxide concentration should be reduced to approximatey fifty per cent. The most important property of nitrous oxide-oxygen anesthesia is that it is non-explosive.

Ethylene: Has been widely used as an anesthetic agent for many years. Ethylene is somewhat similar to nitrous oxide as it does not disturb the normal physiology of the body. With the administration of ethylene, higher percentages of oxygen may be used. However, the explosive properties of this

agent are comparable to that of cyclopropane and ether-oxygen anesthesia.

Acetylene: Has only been used in Continental Europe with satisfaction. Its explosive and toxic properties contraindicate its use.

Intravenous: The intravenous anesthetic agents, evipal sodium and pentothal sodium, are now being used more frequently, especially with the impetus given to the method by its use in the military forces. Penthothal sodium is the agent most frequently used; and it is producing satisfactory anesthesia for a great number of surgical procedures. Pentothal sodium should not be used as the sole anesthetic agent in operations lasting more than one hour. Market relaxation may be obtained with the drug if a deep anesthesia is produced, but this is generally considered not safe. Marked respiratory depression requires immediate treatment with one of the analeptic agents, such as metrozol or picrotoxin intravenously, as well as the administration of 100 per cent oxygen under pressure. The ideal method of using this agent is with a combination of nitrous oxide fifty per cent with oxygen fifty per cent.

Extravenous injection of the solution requires dilution with distilled water if a slough is to be prevented. I prefer a two per cent solution as it tends to decrease the dangers from overdosage and intravascular damage.

Pentothal sodium is especially useful in the aged when properly administered and it may be used in children when given with proper precautions. Evipal sodium is particularly useful in the arresting of ether convulsions in children.

The intravenous anesthetic agents require proper premedication with atropine before hand to prevent vagal and sympathetic stimulation which may occur with these agents.

Rectal: The most frequently used racetal anesthetic is avertin or tribromethanol with amylene hydrate. It is especially useful in these extremely apprehensive or easily excitable patient. Avertin basal anesthesia always requires supplemental anesthesia with one of the gases or diethyl ether. One must constantly watch for postoperative depression and hospitals which are understaffed with nurses should not use this procedure as patients arousing from avertin anthesia require constant observation.

Regional: Spinal anesthesia is still considered as being too hazardous by some surgeons. The hazards of spinal anesthesia are due to the administrator of the agent and very infrequently to the drug. When they administer a spinal anesthetic agent and then leave a nurse in charge of the patient, surgeons are negligent in their duties to the patient. Spinal anesthesia is a safe procedure in the hands of the trained anesthesiologist who understands its capabilities and

KANSAS CITY SOUTHWEST CLINICAL SOCIETY Twenty-Second Annual Fall Clinical Conference

Kansas City, Missouri — October 2, 3, 4, 1944

GUEST SPEAKERS:

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CYRUS C. STURGIS, M.D., F.A.C.P., Ann Arbor, Mich.

OWEN H. WANGENSTEEN, M.D., F.A.C.S., Minneapolis, Minn.

NATHAN A. WOMACK, M.D., St. Louis, Mo.

Round Table Discussion—"The Newer Things in Medicine"—October 2nd.

Public Meeting-October 2nd-

"Postwar Medicine"—Morris Fishbein, M.D., Chicago, Ill.

Symposia:

Gastroenterology; Obstetrics; Pediatrics—October 3rd.

Cardiovascular; Urogenital; Headache and Backache—October 4th.

Joint Meeting with County Medical Societies-October 3rd-

"Medicine Today, In and Out of the Service"—Frank H. Lahey, M.D.

Scientific and Technical Exhibits and Luncheons, Daily. Alumni Dinners—October 4th.

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respiratory depression which may occur. Vascular hypotension may be successfully combatted and prevented by the use of neosynephrine hydrochloride or propadrine hydrochloride before surgery. Ephedrine sulphate is not used because of its cardiac and nervous effects. Fifty milligrams of propadrine hydrochloride are given with the local infiltration. Respiratory paralysis will not occur unless the anesthetic agent has traveled so far cephalad that it involves the fourth and fifth cervical segments. If this occurs, it is only a transient affair and a fatality will be averted by adequate respiratory exchange by the anesthesiologist.

Continuous spinal anesthesia is supplying a great need to the surgeon and anesthesiologist in the prevention of spinal fatalities. Proper levels of anesthesia may be maintained by this method with the administration of small amounts of the drug. Continuous spinal anesthesia will allow the surgeon to experience the same degree of relaxation at the end of the operation as at the beginning without the time factor being so important. Those who use only spinal anesthesia infrequently should use one of the old

standby agents, namely procaine or novocaine instead of the newer agents.

Caudal: The introduction of continuous caudal anesthesia is one of the most important developments of anesthesiology during the past few years. It seems to be answering a real need in obstetrical procedures. It is not only useful in obstetrical procedures, but it has been found to have a definite place in general surgery, especially in operations around the perineal regions. A word of caution is necessary at this time, however; it requires the services of a well-trained anesthesiologist and the use of special equipment. For this reason continuous caudal anesthesia will not be available to all obstetrical patients.

Regional nerve block anesthesia is especially indicated in feeble patients and patients in shock. The length of time necessary to carry out these procedures has greatly retarded progress in this field of anesthesia. Furthermore, marked dexterity on the part of the surgeon is required as well as the services of a trained anesthesiologist. The anesthesiologist particularly must be able to impart to the patient the feeling that he will not experience any discom-



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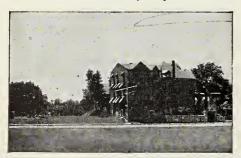
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and one oils, water colors, drawings and sketches executed for *What's New*, Abbott's house magazine to the medical profession, is open to the public. It is hoped that all friends of Abbott will find it possible to attend. Abbott Laboratories, North Chicago, Ill.

fort, while the surgeon must be a great respector of tissues and avoid any unnecessary traction and packing.

The employment of absolute alcohol for the relief of intractable pain is highly recommended when other measures have proved futile or undesirable. When sympathetic pain or causalgia is suspected, blocking the sympathetic nerve supply to the painful area with a local anesthetic solution is of diagnostic value.

The mixing of oxygen with ether, cyclopropane and ethylene render these agents highly explosive and inflammable. This fact need not, however, deter the usefulness of these agents, for, if proper precautions are followed, this hazard will be materially decreased. When these agents are used, in order to increase the moisture content, all rubber tubing should be rinsed in water before they are used. It has been shown that if the moisture content is above sixty per cent, the incidence of explosion is decreased. Good operating equipment is also essential. Proper safeguards must be taken to assure oneself that the system he is using is leak-proof. The use of the Horton intercoupler materially decreases the hazards from explosion. The operating room personnel should furthermore wear shoe with metal cleats attached to rubber soles. Finally, the use of a sparking or motor driven apparatus, cautery and open flames should be prohibited.



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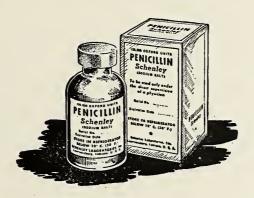
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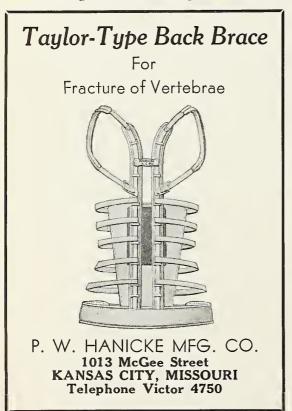
Oxygen and HeliumTherapy: A field of anesthesia in which the average surgeons do not expect the anesthesiologist to be interested is that of oxygen and gas therapy. The well-trained anesthesiologist will assist the surgeons in the prevention of cerebral and cardiac anoxia by the proper utilization of oxygen therapy. The anesthesiologist is constantly on the alert for signs of impending anoxia and if the condition is recognized early, post-operative morbidity will be decreased. Anoxia may manifest itself in various ways either upon the nervous, circulatory or respiratory system. The routin administration of six litters of oxygen without proper consideration of the patient needs are harmful. Oxygen therapy is also beneficial in the prevention of postoperative distention. The subcutaneous use of oxygen in the treatment of angina pectoris and coronary heart disease has also been found of great value by physicians in the field of anesthesiology.

The anesthesiologist, due to his knowledge of the use of gases, has utilized the use of the inert gases such as helium and nitrogen in the medical patient. Helium oxygen mixtures are particularly beneficial to the asthmatic patient as well as in the treatment of infections around the neck where laryngeal construction is present. The utilization of this mixture will frequently tide the patient over the critical periods until surgical intervention is possible. Nitrogen is used in the treatment of shock therapy.

As the anesthesiologist frequently encounters respiratory depression as the result of the anesthetic drugs during surgery, it is no more than proper that the patient who has a marked respiratory depression as the result of an overdosage of barbiturates should have the service of a qualified anesthesiologist. The administration of the analeptic agents requires a knowledge of their site of action as well as indications for the administration of additional amounts. In a barbiturate depression the use of two cc. of picrotoxin may be useless while ten cc. administered with proper precaution would be sufficient to arouse a patient.

For the obtaining of sufficient muscular relaxation under anesthesia, the anesthesiologist frequently uses the nerve paralysing drug curare. This drug may also be used by the medical man for relaxation when he uses metrozol shock therapy as well as the otolaryngologist for bronchial and oesophageal relaxation to facilitate his bronchoscopic procedures.

It is hoped that from the foregoing paragraphs the surgeon and physician may obtain a brief summary of the present status in the field of anesthetic agents and technics. It is futher hoped that a more widespread recognition of their relative values may be obtained with the ultimate idea of benefitting both the surgeon and the patient.





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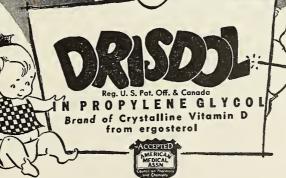


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POST GRADUATE PROGRAM

Not long ago the armed forces were gathering strength for the battles that are today sealing the doom for all Axis nations. You recall how we watched these alert young medical officers leave their homes in Kansas, their families and their practice. You recall our pledge that nothing we could ever do for them would be too much.

That was during the days that we were taking over their patients. It was then that our patriotism was running high. Then all these things were very real to us. And, at the time, we were losing the war.

Someday, perhaps soon, these men will return to Kansas. Confidence rests easily on the shoulders of the victor but under the glamor and the pride that naturally accompanies success in a tremendous undertaking, these officers face a hazardous future. The best meaning cheers soon die away and the most brilliantly earned medal is only of passing interest. In civilian clothes, the officer blends into the community and inconspicuously sets about to earn a living.

munity and inconspicuously sets about to earn a living.

Then the war will be over. The returning doctor will start again where he was just a few years ago. But there is a difference for then he came from school and the courses he studied were fresh in his mind. Today he returns from battle. He has been trained in making reports and more often than not spent long periods away from the actual practice of medicine. Nor was he always allowed to practice in the specialty he preferred.

When he returns, he will want a period of post-graduate medical training. He will want to select specific courses. He will want this ready for him before he begins to practice again and today we can provide such training. The Neurological Hospital, 2625 The Paseo, Kansas City, Missouri. Operated by the Robinson Clinic, for the care and treatment of nervous and mental patients and associated conditions.



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Of course, we could stand back and allow the government to supply his post-graduate education. The nation needed him, the nation took him out of civilian life, the nation made a soldier out of him, let the nation provide for his return to civilian life.

Well, the nation will return him. Our government has already recognized its responsibility and the G. I. Bill of Rights is its answer. On paper the Bill looks good. Apparently, the veteran of at least ninety days service, will be eligible for schooling at government expense not to exceed four years. His tuition, books, laboratory fees and all similar expenses will be paid up to \$500.00 a year and besides that the veteran may receive up to \$75.00 a month for living expenses.

If we accept the face value of its content, the G. I. Bill of Rights apparently promises education free from military or political influence and yet the act has been questioned on this point. The Service Man shall have a choice of study as well as freedom to select a school. But what will he do when the graduate schools are filled? It is probable that these schools, if they can, will give preference to students from their state. Certainly this would be true in Kansas if our Medical School had such resources available!

After these schools have accepted all the students they can take, then what will the doctor do while he waits his turn? Recall, after World War I similar benefits were offered and less than 20 per cent of the doctors actually succeeded in getting enrolled. And among those who did only a portion found the courses they wanted.

You were called in after the last war to receive an offer of a post graduate course in pathology which you were welcome to take or leave. They regretted that the courses in surgery were filled. Did you plan to accept or should they offer this to the next man? And that, you recall, was the government's method of handling this problem before.

There is an alternative; an answer that can solve this question without difficulty. If we organize a graduate school of medicine in Kansas we can then offer the five hundred and more Kansas doctors courses designed for local needs and planned according to their wishes. Let us set our sights high, let us make this a permanent institution, let us prepare standards that will give it an enviable reputation everywhere.

Then make it available to all Kansas doctors who want the highest type of post graduate training. Service men first, of course, but following that any doctor may enroll and courses will be offered on all subjects that are sufficiently requested. They will vary in length to meet the needs of everyone. Instructors will be recognized leaders, both for lecture courses and for clinical work.

Let it become our project, first of all to offer concrete evidence of our desire to help the doctor in service. That is first and your individual attitude toward this whole subject revolves around your acceptance of that responsibility.

There follow various side advantages which you should take into consideration. A graduate department will elevate the Medical School at the University of Kansas to a point where it will take a place beside any school in America. And to the doctor of Kansas, the member of the Kansas Medical Society, it will provide specialized training when he wants it.

However, things of this kind do not just happen. We believe the State will assist in the program. We believe the University will cooperate in many ways but the foundation remains our responsibility. It remains for the individual doctors of Kansas to organize this work and the next few weeks will provide the answer.

Careful estimates reveal that we must raise \$100,000.00 at once if we are to undertake this task. This means almost \$100.00 from every member of our Society. It means that



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your check shall be a donation, given without pressure or duress, given willingly because you have a personal interest in this project.

But do not stop at \$100.00. Would you kindly take a moment to determine exactly what it will cost you in dollars and cents to give \$1,000.00. The government respects your gift to scientific organizations and allows considerable deductions from your income tax for such purposes. Some doctors who investigated learned rather startling things. Already there are pledged three gifts of \$1,000.00 each.

The above will remove the sting but the pride in giving comes from the satisfaction of having fulfilled a promise to ourselves. It is little enough in return for the sacrifices the service man made for us. It is little enough even as a gesture of good will for a man we respect for his profession, and whom we admire as a friend. Sure, it is sentimental, all this, but as we finish, we wonder how else could we better afford to spend our sentiment?

NEWS NOTES

SHORT COURSE FOR LABORATORY TECHNICIANS

The Extension Division of the University of Kansas will conduct a short course at the University of Lawrence for laboratory technicians on Medical Helminthology from October 25 to 28, inclusive. The lectures and laboratory work will be under the supervision of Miss Mary E. Larson, Assistant Professor of Zoology of the University and the work will be of a similar nature to that covered in the July, 1944, short course.

The study of the field of tropical disease is of great im-

portance at this time due to the many men in service who will be returning from tropical climates, and it is important that the laboratory technician be well trained to assist the doctors of medicine in Kansas in this regard. It is hoped that many of the members will realize the need to have their technicians enroll in these short courses. Enrollment fee and other information in regard to the work may be obtained by writing to the University Extension Division, University of Kansas, Lawrence.

MEMBERS

Dr. Harry L. Aldrich, of Cheney, a member of the Kansas-State Board of Health, was the honor guest at a luncheon of the Board in Topeka on June 29, and given a plaque in memory of his thirty years of service on the Board, as a momento for his valuable contribution to the work of maintaining and promoting the public health of the state.

Dr. T. F. Clark, of Waverly, has recently moved to Baldwin.

Dr. C. E. Hardin, of Parsons, has moved to Modesto, California.

MEN IN SERVICE

Comdr. L. R. Pyle, of Topeka, home on furlough was in the office the first of August, looking very fine in his Navy uniform. Commander Pyle, a member of the editorial board has been greatly missed in the Journal office since his departure more than two years ago. He threatens to write another editorial for publication and personally we hope he

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ILAC SIMILAR TO *

keeps his threat, and soon. He is still stationed at the U. S. Naval Hospital in Brooklyn, New York.

Capt. L. B. Putnam, of Wichita, has received the Purple Heart and cluster for multiple wounds, the silver star medal for gallantry in action, the A.T.O. ribbon for meritorous service, the presidential citation ribbon, and a French decoration, so we recently learned from reading the Bulletin. Captain Putnam is resting in England from wounds received in France.

Major George L. Thorpe, of Wichita, has received the soldier's medal for heroism at great personal risk. Major Thorpe is a flight surgeon for a Liberator bomber group, operating from an advance air base in Italy.

Capt. F. J. Eckdall, of Emporia, is now stationed at Camp Beale, California. He was formerly stationed at Greeley, Colorado.

· Lt. Clifford VanPelt, of Junction City, is stationed at Seattle, Washington.

Capt. Richard E. Baldridge, of Kingman, has asked for an address change for his Journal. He was formerly stationed at Memphis, Tennessee, and will now have an APO address out of New York.

Major M. C. Martin, of Newton, has written the Journal to change his address to Camp Crowder, Missouri.

Capt. C. R. Kempthorne, of Manhattan, is stationed at Camp Barclay, Texas.

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MEDICINE — Two Weeks Course in Internal Medicine starting October 16.

GYNECOLOGY — Two Weeks Intensive Course starts October 2. One Week Course Vaginal Approach to Pelvic Surgery starts October 23.

OBSTETRICS — Two Weeks Intensive Course Starts October 16.

ANESTHESIA — Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

GASTROSCOPY—Personal Course starts October 2.
OTOLARYNGOLOGY—Two Weeks Intensive Course starts October 2.

ROENTGENOLOGY — Courses X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.

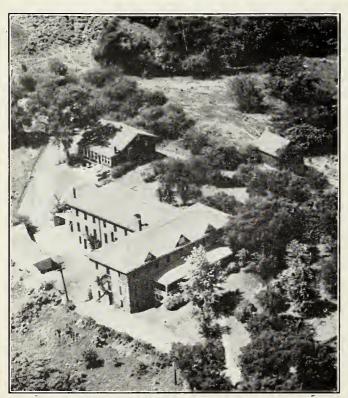
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*Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245.

**Laryngoscope, 1935, XLV, No. 2, 149-154.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend-Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

Lt. Henry S. Blake, U. S. Navy, was a recent visitor in Topeka. He is now stationed in Washington where he has a responsible position in the joint Red Cross, Army and Navy board in charge of blood donor centers.

Lt. Warren A. Plowman, brother of Dr. C. W. Plowman, of Jewell, has recently been sent oversea. He was formerly stationed at Indian Gap, Pennsylvania.

Capt. L. B. Mellott, of Bonner Springs, has been transferred from Santa Barbara, California, to Centralia, Washington.

Capt. A. S. Steinzeig, of Kansas City, has been transferred from Inglewood, California, to Seattle, Washington, where he has an APO address.

Lt. R. C. Jefferies, of Atchison, has been transferred from Kansas City, Missouri, to the Naval Hospital at Great Lakes, Illinois.

Capt. J. T. Marr, of Sterling, has been transferred from Camp Gordon Johnson, Florida, and is now in the X-Ray Department of the Air Service Force Convalescent Hospital at Daytona Beach, Florida.

Capt. L. W. Zimmerman, of Liberal, stationed in the Pacific, has been transferred to Carlsbad, New Mexico.

Major Donald A. Kendall, of Great Bend, is on the general staff at Winter Hospital in Topeka.

Mrs. V. A. Vesper, of Hill City, writes the Journal requesting that Captain Vesper's Journal be sent to him at his APO address out of New York.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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Topeka, Kansas

AUXILIARY

PRESIDENT'S MESSAGE

My message will be brief this month in order to leave space for articles by the various state chairmen. I plan to visit each Auxiliary this year and would like to attend one of your regular meetings. Without neglecting my home duties, I believe I can visit two Auxiliaries a month.

In beginning our fall program let us remember that, "Success is purchased not with money but with thought, effort and time."

Three sign posts on the road to success in our Auxiliary program are: (1) membership, (2) bulletin, (3) hygeia.

Mrs. Leo J. Schaefer.

PRESS AND PUBLICITY

MRS. E. R. MILLIS, Chairman

My aim this year as Press and Publicity Chairman is to have news items in the Journal of the Kansas Medical Society from every Auxiliary in the state. As soon as your meetings are over please send me your programs. They must be in my hands by the first day of the month. Here is the form for your report:

- a) Name of county auxiliary
- b) Place of meeting
- c) Date of meeting
- d) Number present (members), (guests
- e) Name of speaker
- f) Subject of address
- g) Questions discussed
- h) Actions taken thereon
- i) Name special projects
- j) Report how material sent by chairmen of committees of state auxiliary is used.

Send me also clippings of current events for our scrapbook.

HYGEIA

During these war years, our thoughts naturally turn to the health and nutrition of our families. What is more necessary than to have the best and latest information on these subjects presented in the simplest manner?

Hygeia is an answer to these questions. It gives us a reference book, through which we can with ability, maintain our family's health. It enables us to answer intelligently questions which our friends and neighbors ask, in a manner approved by the American Medical Association. Hygeia is one of the few ways in which doctors can ethically bring vital health facts before the public.

The Women's Auxiliary to the American Medical Association has made the promotion of Hygeia one of their major projects. These subscriptions are especially welcome as Christmas gifts. Try placing them in the hands of nursing instructors with your hospital or home nursing courses. Colleges, high schools and grade schools value them in their libraries. They are read widely in community centers as well as in your own doctor's office.

While going through Winter General Hospital at Topeka, during our state medical convention, I noted that Hygeia was not on the magazine rack unread. It was in the hands of a soldier who was very intent on one of its

articles. Why not give it to a U. S. O., military recreation center, or one of our many hospital libraries?

Young mothers value the articles on child care and nutrition. It makes a welcome entry into the home, particularly now with so many doctors in the armed services and the remaining few so overworked.

For the following year, Hygeia will include articles by the most eminent authorities on foods, baby care, child feeding, health problems, and lunch box questions, so vital to our children and to the defense laborers in our over crowded communities. All of these articles will be presented in a common sense, practical manner which can be understood by all. They are chosen for their sound medical value in presenting subjects which are nearest our hearts, during these turbulent times when the layman's understanding of medicine and its independent spirit is so necessary to the lives and professions of our doctors. Now, as never before, the doctors stand on trial and the greatest thing we as doctors' wives can do is to present their work to the laity with every available means. This is so ably done through subscriptions to the doctor's own magazine, Hygeia.

Our plan for the year 1944-1945 is to ask every member of the Women's Auxiliary to take the responsibility of placing at least two subscriptions to Hygeia, one of which may be her own. Won't each of our members stop a moment to check her own subscription to Hygeia to see if it has lapsed? Will you not then see your own County Hygeia Chairman and give her a renewal to this magazine, also at least one other subscription?—Mrs. John A. Billingsley, Chairman, State Hygeia Committee.

PROGRAM

MRS. N. C. MORROW, State Program Chairman

An excellent program for the coming year has been planned by the National Program Chairman, Mrs. Wm. J. Butler. Under Article No. 2 of the National Constitution, the first objective is "to extend the aims of the medical profession to all organizations which look to the advancement of health and health education." To achieve this object we must first of all education ourselves, study the history and purpose of the American Medical Association, and certainly we should know the history and objectives of the Woman's Auxiliary to the American Medical Association.

The doctors' wives in your Auxiliary will be interested in programs dealing with the aims of the medical profession and the advancement of health education such as the following:

- (1) Hygeia consult your magazine for material.
- (2) Proposed medical legislation both state and federal.
- (3) Medical education; postgraduate education; medical and hospital service plans; rehabilitation program.
- (4) U. S. Cadet Nurse Corps project.
- (5) Juvenile delinquency.
- (6) Advancement in medical science such as penicillin, tropical diseases, etc.
- (7) Transcribed radio programs and posters on health films and health topics may be obtained from Dr. W. W. Bauer, 535 N. Dearborn St., Chicago, Ill.
- (8) Publicize American Medical Association network broadcasts. These will be announced in the American Medical Association Journal.

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RENAL TUBERCULOSIS*

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Kansas City, Kansas

Renal Tuberculosis, while a relatively uncommon urinary infection, is encountered with sufficient frequency so that it must be considered in the differential diagnosis of any refractory urinary tract infection. Early diagnosis is imperative in order to manage the treatment so that the optimum results are obtained. The patient who is allowed to develop a well established tuberculous cystitis lives in a miserable existence, since the changes in the bladder may be irreversable. Where possible, and in many cases it is possible, the kidney infection should be diagnosed and treatment instituted before bladder infection occurs.

In order to evaluate the entire situation, it is necessary to review the pathogenesis and pathology of the original kidney lesion, and to outline its progress. All authorities now agree that the disease is never primary in the kidney but is borne to the kidney hematogenously from some primary focus elsewhere in the body, or from an established secondary focus, such as tuberculosis of the bones or joints. Sometimes an active infection elsewhere can be demonstrated, but often it is not possible to do so. The assumption has been made that tubercle bacilli can remain dormant for long periods of time, probably in lymph nodes, and at some subsequent date give rise to a tuberculous bacteriemia, establishing an active infection in the kidney, but without producing generalized miliary tuberculosis.

The work of Medlar and his co-workers^{1,2} has thrown interesting light on the early renal lesions in tuberculosis, as well as on the significance of tuberculous bacilluria, and upon the possibility of healing of the initial renal lesion. In studying the disease in rabbits and guinea pigs, where an acute miliary tuberculosis was produced by injecting live organisms into the animals, renal infections were pro-

duced which closely simulated the early lesions in man. The animals were sacrificed and serial sections made of both kidneys. It was found that the initial renal tubercles were multiple; and also bilateral focal infections were the rule (eighty-eight per cent of the animals). The initial tubercles occurred usually in the cortical zone, where the flow of blood is slowed in the glomerulus; it occurred occasionally, however, in the cortico-pyrmidal area, or in the medullary area where there are small vessels. Subsequently Medlar examined, again by the serial section method, forty-four kidneys in thirty patients dying from extra-urinary tuberculosis in whom no urinary symptoms were found. Of these two cases showed no renal tuberculosis, in twenty-two definite renal lesions containing tubercle bacilli were found, and scars of healed lesions were found in fourteen of these; in the remaining six only healed scars were found. The distribution of the active lesions was predominently cortical (seventy-five per cent), although some were cortico-medullary, (thirteen per cent) and medullary (thirteen per cent). If Medlar's interpretation of the scarring is correct, it suggests that the disease is definitely hematogenous, and is bilateral, at least at the onset, more important, however, it proves that the initial lesions can, and often do, heal spontaneously.

Another difference of opinion which still exists is whether the appearance of tubercle bacilli in the urine always means renal tuberculosis, or whether the normal kidney can excrete organisms. Medlar believes that tuberculous bacilluria means renal tuberculosis, which is logical on the basis of the above investigations. This is supported by the work of Harris³ who studied the urine of forty-three adults and sixty-seven children with active bone tuberculosis. Guinea pig inoculations and smears were made on each patient at intervals of two months. In the adults thirty-seven per cent, and in the children 13.4 per cent had tubercle bacilli in the urine either constantly or intermittently. In those cases with positive urinary findings fifty-seven per cent of the adults and ninety per cent of the children were free of urinary symptoms. The consensus today is that tuberculous bacilluria means renal tuberculosis, if

^{*}Presented at the annual meeting of the Kansas Medical Society, in Topeka, May 10, 1944.

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the male genital tract is exonerated. There is also definitely the feeling that the early lesions, and sometimes more advanced lesions, can and do heal.

Following the development of the early cortical lesion, or lesions, one of three courses may occur. First, the lesion may heal as any other tubercle; second, the lesions may be merely part of an overwhelming miliary tuberculosis, and the patient may die, usually without primary symptoms; or third, chronic renal infection may be established, which usually progresses, and which may be bilateral from the onset. The usual sequence of events is that the cortical tubercle enlarges to form an abscess, and that the infection invades the collecting tubules, thence progressing downwards to involve the renal papilla, (seen in the pyelogram as a fuzzy or "motheaten" appearance). The renal pelvis, and its submucosa is then infected, causing thickening and rigidity of these structures. The kidney parenchyma is also further involved by retrograde infecton, resulting in further abscess formation, which ultimately leaves a shell of renal tissue filled with abscesses (caseo-cavernous renal tuberculosis). While these changes are going on the infection proceeds down the ureter, producing the characteristic dilated and rigid ureter, with hyperplastic mucosa. Unless the ureter undergoes complete stenosis from the inflammatory process (producing autonephrectomy), sooner or later in this chain of events, tuberculous cystitis is established, and changes occur in the bladder similar to those in the renal pelvis and ureter. Once tuberculous cystitis is established, it does not heal while being bathed in the products of the infected kidney. The bladder becomes progressively more irritable, and usually becomes small and contracted. This may result in stenosis of the opposite ureter, with hydroureter and hydronephrosis, with accompanying ascending infection, often tuberculous, marked impairment of renal function, and death from renal failure.

From the discussion of the pathogenesis of renal tuberculosis, it is apparent that, like tuberculosis elsewhere, it should not be regarded as a disease of one organ alone, but as a manifestation of systemic tuberculosis. For this reason, while the urinary tract disease may dominate the clinical picture, one must always remember to evaluate the entire situation so that other foci of tuberculosis may be found if present, and so that the patient's general resistance to tuberculosis may be evaluated, and the optimum time selected for surgical intervention, if indicated. This concept is not a new one, but it is being recognized and emphasized more all the time.

The clinical picture of renal tuberculosis is not prominent until the bladder is invaded. Prior to the development of cystitis renal tuberculosis is relatively silent, althought in an occasional case the patient may notice mild or moderate renal pain, gross pyuria, or hematuria. Fever is not consistently present, so the disease may remain unrecognized until the symptoms of bladder irritation make their appearance. In order that the diagnosis may be made earlier, routine urinalyses should be done on patients who are seen with totally unrelated complaints, and symptomless pyuria should always be investigated. In patients with known tuberculosis infection elsewhere, periodic urinalysis should be routine. Thomas⁴ advises that all patients with tuberculous infections should have routine urinalyses every three months, and that if cellular elements (erythrocytes or leucocytes) are found in the urine, complete urological study, including well filled retrograde pyelograms should be carried out.

When tuberculous cystitis supervenes, frequency and dysuria make their appearance. This usually starts with mild pain on urination, and increased frequency, and progresses to exceedingly severe frequency, urgency, dysuria, usually with gross blood and pus in the urine. In far advanced cases, when the bladder has become heavily infected and contracted, voiding may occur every few minutes, amounting practically to incontinence. Usually by this time the opposite ureteral orifice has become stenotic, and ascending infection on the obstructed kidney may supervene at any time.

Classically, in urinary tract tuberculosis, there is an acid urine, loaded with leucocytes and often erythrocytes, in which no organisms are found on methylene blue stain. This is because the tubercle bacillus tends to render the urine strongly acid, and other organisms grow in it with difficulty. The tubercle bacillus itself is not readily stained by the usual methods, and requires special staining methods for its identification. It is true, however, that often the classical urinary findings are not present, and a mixed infection occurs, rendering the urine less acid and enabling the identification of other organisms with the usual stains. Therefore it must be borne well in mind that any urinary infection, which resists modern urinary antiseptics after a fair trial, should be suspected of being tuberculous, and this possibility should be very thoroughly investigated.

The diagnosis of renal tuberculosis is established by finding tubercle bacilli in the urine. If the disease is suspected, every effort should be made to identify the organism, staining of the sediment in a twenty-four-hour urine sample with Ziehl-Nielsen Stain, guinea pig inoculation, and culture of the urine are the methods available. They must be carried out repeatedly in some cases before one can be sure the organism is not present.

Even if the organism cannot be found, but one is

still suspicious of the diagnosis, retrograde pyelograms should be made, and specimens from each ureter similarly examined. If the organism is identified, one proceeds similarly with retrograde pyelograms as it is essential that one should know the location and extent of the renal lesion, and whether the disease is unilateral or bilateral. There is still some dissent in the matter of whether intravenous or retrograde pyelography should be used, because of the theoretical danger of carrying infection from the bladder into an uninfected kidney. Most authors feel, however, that the likelihood of introducing infection into a normal kidney is more theoretical than real, and the sharpness of detail of retrograde pyelograms, as well as the fact that the urine from both kidneys can be studied carefully, outweighs the danger of passing catheters up the ureters. It may be necessary in some cases to repeat urograms at intervals in order to evaluate the proper management of the situation, in deciding whether surgical intervention is indicated.

Accurate diagnosis, then, can be established only after thorough urological examination, often with repeated urinalyses and pyelograms.

Once diagnosis is established, it is necessary to decide whether surgery is indicated or not. If the disease is unilateral and advanced, and the contralateral kidney shows an entirely normal pyelogram, and entirely normal urine is obtained from it, removal of the diseased kidney is indicated. However, tuberculosis elsewhere in the body may be a factor in even this decision. If the patient has pulmonary tuberculosis, for example, which is showing progression of the lesion under adequate care, it is an index that resistance to tuberculosis in that individual is not good, and nephrectomy may precipitate miliary tuberculosis, increase of the extra-renal lesion, or the nephrectomy wound may not heal properly due to the development of tuberculous sinuses. If the patient, however, has extra-renal tuberculosis which is improving, then this evidence of relatively good resistance and the prognosis improves.

In very early renal tuberculosis, where the disease is diagnosed by obtaining pus and tubercle bacilli, but where no pyelographic changes are present, there seems to be a very definite trend among competent urologists not to subject the patient to nephrectomy on the evidence alone, if there is no bladder involvement (Thomas, Stebbins and Sandell, Beach and Shultz⁶). It seems wiser to place such patients under a careful medical regime, and to observe the progress of the lesion, and resort to surgical interference only when progress of the lesion or bladder involvement constitutes an indication for nephrectomy. Several apparent cures, as judged by clinical criteria, have been obtained in these cases.

Even when a minimal lesion showing destructive change exists, occasionally clinical healing may result (Creevy⁷), but this is exceedingly rare.

When the renal infection is bilateral, no surgery is indicated unless far advanced destruction is present in one kidney, and only minimal disease in the other. Braasch and Sutton⁸ have recently reviewed this subject. Their series included 291 cases, of whom eighty-seven were subjected to nephrectomy because of marked destruction in one kidney, with only slight diseases in the contra-lateral one, and where they felt that the removal of one kidney would benefit the patient symptomatically. These authors were also able to follow the clinical course of 167 of the remaining patients in whom nephrectomy was not performed. The survival rate in this latter group was much better than the previous impression has been. At three years seventy-two per cent were still alive, at five years fifty-eight per cent, at ten years twenty-six per cent, and at fifteen years sixteen per cent. While the mortality is still high, these figures indicate that it is not as high as one would expect with advancing renal disease of this type.

SUMMARY AND CONCLUSIONS

- 1. Sound fundamental understanding of the pathogenesis of renal tuberculosis is essential in diagnosis and management of the disease.
- 2. Tuberculosis must always be suspected in refractory urinary infections.
- 3. Careful and thorough urological investigation must be carried out in all suspected cases.
- 4. Renal tuberculosis should be regarded, since it is never primary in that organ, as part of the picture only, bearing in mind that the patient has, or has had, tuberculosis elsewhere.
- 5. There is a definite trend toward intelligent conservatism in certain selected cases.

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Tuberculosis remains predominantly a disease of adults in their productive years and causes invalidism, loss of earning power, expense of hospitalization and treatment.-A. C. Reid, Jour. Industrial Hyg. and Toxicology.

FETAL ASPHYXIATION*

Robert E. Pfuetze, M.D.

Topeka, Kansas

At birth, the new-born baby enters a critical phase of its continued existence. Its survival depends upon many adjustments, but it must, first of all obtain oxygen from the air and rid itself of carbon dioxide. Many natural, accidental or artificial factors frequently combine to prevent the initiation of breathing and we, too frequently, hear the remark, "The baby's heart was beating but it wouldn't breathe," in spite of efforts at stimulation.

In my experience of 2404 consecutive deliveries, about half of them made by interns, only one baby born alive failed to breathe. This baby was without a diaphragm on one side and had an incompletely developed lung and diaphragm on the other. All four babies requiring one-half hour or longer to resuscitate, died subsequently. Two babies were found to have large brain hemorrhages at autopsy and two clinically appeared to have brain injury. The uncorrected stillbirth rate for this series was 1.91 per cent. No complicated apparatus was used for resuscitation; only simple methods, available to everyone, were stressed. I believe that they were largely responsible for the low mortality.

Breathing in the normal individual is the result of an outflow of nervous impulses from the respiratory center. With an increase of carbon dioxide at the center, breathing is stimulated, the CO2 is eliminated and additional oxygen is made available. When breathing is interfered with and oxygen is not available, CO2 and lactic acid are accumulated to such an excessive degree that respiratory efforts, at first violent, finally cease and the respiratory center cannot be further stimulated. Eastman¹ has shown that the picture of apnea at birth is largely that of an extremely low level of oxygen in the blood, combined with a high CO2 and lactic acid content and a low pH. Alpha Lobeline, Coramine, Metrazol and carbon-dioxide will have no effect unless the respiratory center is first activated by ventilation of the lungs. This situation is seen in drowning. It is evident in the new born as Asphyxia Pallida. While some reflexes may be present at birth, if breathing is not initiated, the baby becomes limp, and stimulation gives no reaction. The baby has a greyish pale appearance, its sphincters relax, the muscles about the neck, mouth and larynx collapse, and the heart becomes markedly slow and feeble. When the lungs of such an infant are ventilated with air or oxygen, the heart, at once, begins to beat faster and more

*Presented at a meeting of the Golden Belt Medical Society on July 6, in Manhattan, Kansas. vigorously. The color returns to pink, reflexes and muscle tone return, the baby gasps two or three times and then begins a rhythmical respiration which can be further stimulated by carbon dioxide and various drugs.

If asphyxiation does not result in death of the baby, more or less permanent damage may be done to the central nervous system if the condition is not improved promptly and efficiently. Experimentally, it has been shown that newborn animals which have been asphyxiated show various phenomena2 including (1) weakness and tremors, (2) delayed and incoordinated efforts to right themselves, (3) flaccid or spastic paralysis often lasting several days, (4) convulsive twitchings and epileptiform convulsions, (5) motor weakness and lack of control over the muscles of the face and mouth. When a similar picture is seen in the newborn, one hestitates to predict a bright mental future for the baby. In a group of 252 mentally-deficient children in whom a reliable birth record was obtainable, Schreiber³ of Detroit, found 176 to have a history of asphyxia at birth. It has been suggested that painless labor may be associated with the increase in the number of patients in insane asylums.

Of the single or combined factors producing various degrees of anoxemia or asphyxia of the newborn, one of the most common is prematurity. Here the respiratory center is often incompletely developed. Narcotics, anaesthesia, trauma or other factors have a greater depressive effect and often persist for a greater length of time than in the more mature infant. Any asphyxiating factor, combined with the generally poor resistance and muscular feebleness, characteristic of these infants, may make the difference of life, death or permanent cerebral disorder.

Any drug or anaesthetic given to the mother will have a greater or lesser effect on the baby, depending upon the amount and time of its administration. The infant will pay the price of more frequent asphyxiation because of the relief of pain for the mother. Of the many drugs used, those producing regional or local anaesthesia (Novacaine) will have the least effect on the baby. If properly given, local anaesthesia will have no effect on the baby. Volatile inhalation anaesthetics depress the infant in proportion to the amount and length of time they have been given. Their residual effect after the birth of the baby is probably more transient than is the case with analgesic drugs which often have a prolonged action, keeping the baby sleepy for many hours. Although many methods of drug analgesia have been advocated, none are without danger to the infant. The physician who uses them should be acquainted with their hazards and prevent or be prepared to counteract them.

Changes affecting health and circulation in the mother or baby are frequent causes of various degrees of asphyxia. Toxemia of pregnancy and metabolic diseases increase the frequency of asphyxia. In a study of 2000 cases by Lund⁴, thirty per cent to forty per cent were affected. Placental circulation is interfered with in tetanic contraction of the uterus, early separation, infarcts, syphilis and erythroblastosis. Knots in the cord and pressure on the cord in prolapse or breach delivery are easily recognized factors. Congenital malformations of the baby in many ways affect the circulation or respiration.

Intrauterine aspiration of amniotic fluid and meconium in a transient period of asphyxia and foetal distress or aspiration of thick mucus and blood in the birth canal may block the trachea and smaller bronchioles. The irritation may precede pneumonia and partial atelectasis. The finding of amniotic debris in the lungs at autopsy is an indication of intra-uterine asphyxiation as the inciting cause of pneumonia or regional atelectasis. In one case at the Chicago Lying-In Hospital, respiration was obstructed by a piece of placenta bitten off by the aftercoming head in a case of placenta previa.

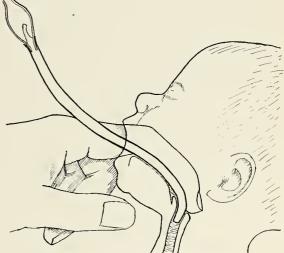
Some degrees of asphyxia may result from birth trauma and complications of labor. Precipitate deliveries may be a factor but more commonly, a greatly prolonged second stage will produce a high degree of asphyxia. Operative delivery is associated with a greatly increased incidence but is frequently combined with other causes. Asphyxia is common among babies delivered by Cesarean section and the stillbirth and neo-natal death rate in this and most series is higher than the general average.

Treatment of asphyxia should begin with prenatal care in eliminating as many contributory factors as possible. The period of labor is exceedingly important and the conduct of the case should be regulated with a definite regard for the asphyxiating effects on the infant. Caution should be exercised to prevent an undue number of asphyxiating factors to be present in the same case. Non-volatile analgesics should be given very sparingly or not at all in cases of premature delivery. When delivery is imminent, the pelvic outlet can be very effectively anaesthetized by local infiltration at the site of episiotomy and blocking of the pudendal nerves.

When a baby is born, it should be cared for as though asphyxia and shock were expected. As soon as the baby's head emerges, mucus squeezed out of the baby's chest should be milked out of its neck and mouth and wiped away. A soft rubber ear syringe can be inserted quickly into its mouth and throat and mucus aspirated before the first breath. The baby should then be held briefly in the lap of the obstetrician to allow additional blood to flow into

the baby from the placenta. As much as 100 cc. additional blood may be given to the baby if clamping of the cord is delayed.

The baby may be stimulated to breathe by rubbing its back, slapping its feet or shaking it gently. Not one baby in this series had been held by its feet and spanked as is done in the movies. To do so increases the shock already present and may aggravate a small or beginning brain hemorrhage. If breathing did not begin immediately, the baby was covered with a towel, the mucus removed from its trachea by a catheter and artificial respiration begun. No delay should be allowed in trying less efficient or more shocking methods lest permanent damage result to the baby's brain from the prolonged anoxemia. Drugs stimulating respiration have no place in this immediate phase. As was pointed out earlier in this paper, they have no effect on the severely asphyxiated baby and onset of their action is far too slow unless given intravenously to the mildly asphyxiated babies. Furthermore, if they have no value in the severe cases and work too slowly in the mild ones, their use may be dispensed with, except to aid in continuing respiration once established.



Method of Inserting Tracheal Catheter

A great many simple and complicated machines have been invented to carry on artificial respiration in the newborn and many of them are very good. The Drinker 'Iron Lung' is perhaps the most spectacular. A tracheal catheter,* however, may be purchased for \$1.00 and is all that is needed in the way of equipment. With it, mucus may be effectively aspirated from the mouth and trachea and respiration established. To use it, the baby's head should be extended somewhat and the index finger inserted (Continued on Page 353)

^{*}Adams Cacoprene No. 14 Fr. is a satisfactory tracheal catheter for most babies; No. 12 Fr. for prematures.

MEDICAL SCHOOL

A CASE OF COMPLETE ABSENCE OF THE INFERIOR VENA CAVA

Homer B. Latimer Herbert H. Virden* Lawrence, Kansas

Complete absence of the inferior vena cava is an unusual anomaly but it is not hitherto undescribed. Regan ('29), in his review of the earlier literature on this subject says (p.200) that Stark in 1835 found five mammalian cases "in which the postrenal vena cava drained by a path, not through the liver but through the enlarged azygous veins." In 1925 McClure and Butler published an excellent study of the development of the inferior vena cava in man and in 1929 McClure and Huntington published a complete review of the literature on the variation of the vena cava in man and in other mammals and an exhaustive study of the variations found in the cat. Seib ('34) studied the azygous system of veins in some 200 cadavers and attempted to interpret his findings from the embryological development. In doing this he suggested that the development of these vessels is even more complicated than the condition suggested by McClure and Butler and by McClure and Huntington. The most recent contribution to this subject, so far as is known, is the description of a case of complete absence of the hepatic portion of the inferior vena cava in a stillborn full term, female fetus by Huseby and Boyden ('41).

It is not our purpose to enter into a discussion of the controversial and rather complicated development of the inferior vena cava, but merely to report this additional case with the hope that it may add some light to this rather old and involved problem.

Huseby and Boyden, after a careful review of the literature, feel that their case is the fifteenth on record with absence of the hepatic portion of the inferior vena cava. This would make this the sixteenth described case of complete absence of the inferior vena cava. Modifications or duplications of the abdominal portions of the vena cava inferior are more frequent than the complete absence of the hepatic portion.

OBSERVATIONS

The anomalous inferior vena cava was found in a cadaver which was being dissected by the freshman

medical class and we wish to express our most hearty thanks to Mr. Donald Lloyd and Mr. William Shinkle who were dissecting this cadaver and who recognized that something was abnormal and called our attention to it.

The body was that of an adult, white male, past middle life. He was a large man, heavily muscled and with much fat. Unfortunately we have no record of his age, name, or cause of death as all of these data were lost in the fire which destroyed the anatomy building. The body was not well preserved which made it difficult to get some of the details which we wish we could present. The two students dissecting this cadaver found many minor variations in the circulatory system of the upper extremities. The thorax was dissected after the upper extremities and in this dissection what was supposed to be an unusually large azygous vein was discovered together with the absence of the left azygous system. Then the abdominal cavity was opened and the absence of the entire inferior vena cava was discovered, and the body was put aside for further careful study and dissection. We again wish to express our gratitude to these two students who willingly left this cadaver to complete their dissection on another specimen.

This case is much like that described by Huseby and Boyden and it is most like group II of type sixteen of McClure and Huntington, or with all of

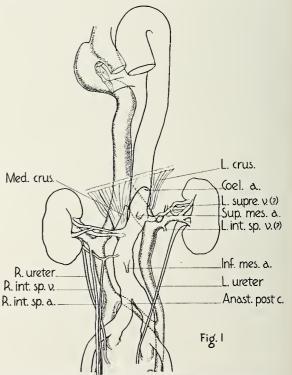


Fig. 1. Drawing of the supracardinal system of an adult, white, male cadaver. Aorta and its branches unshaded. From the top of the aortic arch to the bifurcation of the abdominal aorta measured 13.5 inches in the cadaver.

^{*}Department of Anatomy, University of Kansas School of Medicine.

the blood from the abdomen and lower extremities going through the azygous vein to the superior vena cava and not passing through the liver. Unlike the case described by Huseby and Boyden, this cadaver had no left azygous system.

An apparently normal portal vein entered the porta of the liver. The hepatic veins, instead of leading to the inferior vena cava, all united to form a single hepatic vein which followed the course of a normal inferior vena cava through the diaphragm and into the inferior part of the right atrium.

In the inguinal region, the femoral nerve, femoral artery and femoral vein were normal in position and size, but a short distance above the inguinal ligament the left external iliac vein passed dorsal to the artery and then came to lie on the lateral side of the artery (Fig. 1). The right external iliac vein also crossed posterior to the corresponding artery but on this side it did not shift its position until it was about half way from the inguinal ligament to the sacral promontory. In the region of the sacral promontory there was a venous anastomosis between the two sides and dorsal to the artery, which very likely is the remains of the post cardinal anastomosis (Anast. post c., Fig. 1). The two paired veins, probably the right and left postrenal supracardinals, then ascended to the region of the kidneys, or to the renal collar of McClure and Butler.

There is an interesting multiplication of the renal arteries. The figure shows but a single renal artery on the left side but this divides into three rami before it reaches the kidney. On the right side a single trunk very soon divides and the upper one of these divisions again divides, thus providing three renal arteries as on the left side. Then, lower down and arising on the anterolateral side of the aorta is another branch which divides into the right internal spermatic artery and a fourth renal artery. This most inferior renal artery enters the kidney below the hilum and passes posterior to the right internal spermatic vein (R. int. sp. v.).

The right renal vein was normal except that it received the right internal spermatic vein (R. int. sp. v.). The left renal vein was made up of three veins leaving the hilum of the kidney but emptying into the left supracardinal as a single vein. Unfortunately we were not able to identify positively a left internal spermatic vein or artery. The short stub (L. int. sp. v. (?)) extending inferiorly from this renal vein may represent the proximal end of the left internal spermatic vein but of this we are not sure. As stated above, this cadaver was not well preserved and these vessels were torn before we came to examine the cadaver. It seems probable that this is the proximal end of the left internal spermatic vein but we are not sure. There was also a short piece of

a vein extending superiorly from the left renal vein which likewise may have been a suprarenal vein (L. supre. v. (?)) but again we are unable positively to identify it as such, although it probably does represent the lower end of the vein to the left suprarenal gland.

The left kidney had a large cyst (not shown in the drawing) which covered the anterior middle half of the kidney. The right kidney was normal. The two ureters arose in a normal manner and their courses were normal on both sides. Both ureters passed anterior to the veins, thus giving evidence that these veins were developed from the embryonic supracardinals.

After receiving the left renal veins, the left supracardinal turned medially, passed behind the aorta and then superiorly through the aortic hiatus of the diaphragm, together with the aorta, but behind it as shown in the figure. The right supracardinal passed through the right medial lumbocostal arch and a short distance above the diaphragm it received the left supracardinal vein. Thus the two supracardinals were separated by the medial crus of the diaphragm (Med. crus) in passing into the thoracic cavity.

The single large vessel ascended slightly to the right of the midline of the vertebral column, and then it turned a little to the left of the midline behind the right atrium and then turned in a semicircle to the right and superiorly, passing over the root of the right lung and emptying into the superior vena cava, which seemed to be normal in all other respects. There was a slight aneurysm of the arch of the aorta, which is not well shown in the figure.

It is hoped that this case may aid in more completely elucidating the development of the inferior vena cava, but in addition to this, it does give a most interesting picture of an arrested embryonic development. Unlike the case described by Sparks and Fox ('38) in which the inferior vena cava had been occluded and persisted as a solid fibrous cord, this man had retained the embryonic condition throughout his entire life, and a normal inferior vena cava failed to develop.

The lowest part of these vessels, or the external iliacs, may be thought of as developed out of the postcardinal anastomosis in the iliac region, then more superiorly, the two venous channels represent the right and left postrenal portions of the supracardinals, and these in turn were continued superiorly into the right azygous vessels, or right thoracic supracardinals. The left thoracic azygous vessels in this specimen had entirely disappeared. The arched portion of the azygous vessel represents the old right postcardinal. Of course this listing of the remnants of the embryonic vessels in no way accounts for the

(Continued on Page 353)

President's Page

To the Members of the Kansas Medical Society:

For the past decade cancer has maintained second position as a cause of death in Kansas, preceded only by heart disease. The Women's Field Army of the American Society for Control of Cancer has carried on a splendid campaign in cancer education, but they are in need of local workers in the various counties. If any of you know of some woman that would make a good worker in this cancer prevention program, I would appreciate it if you would write to Mrs. Daisy Johntz, Abilene, Kansas, and give her the woman's name.

The Kansas State Board of Health has done little in the past to stimulate interest in cancer control. This has been due largely to lack of funds to finance the program.

Legislation is proposed to establish within the Kansas State Board of Health a Division of Cancer Control, which would work closely with the Cancer Control Committee of the Kansas Medical Society and with the Women's Field Army, in building and adapting the program to meet the needs of our state.

Sincerely,

M. Trueheart. M. D.

President, the Kansas Medical Society

EDITORIALS

CRIPPLED CHILDREN COMMISSION

Elsewhere in this issue may be found a letter from Mr. Charles J. Chandler, Chairman of the Kansas Crippled Children Commission, and a bulletin prepared by the Commission regarding poliomyelitis.

Heated discussions on the Kenny treatment brought this subject into prominence and the Kansas Crippled Children Commission was compelled to declare a policy for these cases.

It is only natural that in the course of debate the Commission should become involved. At times isolated instances have been cited as indications of general policy even though this was not necessarily the case. At other times the Commission has been credited with acts for which it was not responsible or over which it had no control. And there are instances where community hysteria has occasioned action that would not have occurred during periods of calm.

All of this is merely a way of saying that misunderstandings can hamper a highly worth-while program. The frank statement by the Commission is its own effort to clarify its position regarding the acceptance for care and treatment of children with acute poliomyelitis. The Journal publishes this statement because it is directed to you by the Commission and welcomes whatever comment you care to make.

TABOO ON GOVERNMENT MEDICINE

Much is being heard these days about governmental controlled health services. Indeed, certain savants are beating the bushes for support of a program which, if accepted, would place all medicine and hospitalization in the hands of picked bureaucrats.

What the American public thinks of such a scheme is illustrated by a factual study conducted by the Michigan Health Council. This study was for the purpose of determining sentiment as between a professionally-sponsored health program and the proposed tax-supported scheme.

Of some 5,000 persons interviewed in Michigan, 33.7 percent voted for professionally-sponsored voluntary plans, and 15.5 favored a tax-supported Government program. In other words, the testimony was preponderately in favor of leaving the health of the nation in the hands of the trained doctors and nurses rather than turn it over to any sort of Government control plan.

This survey will not deter those committed to an all-out Government health control program. But it

tends to show that the American people do not trust bureaucracy on such vital matters as health, hospitalization, when the present medical profession is capable of rendering all services needed to keep the people healthy.—*Topeka Daily Capital*, Friday, September 29, 1944.

LETTERS FROM SENATORS

For some months the U. S. Senate has been studying the Agriculture Organic Act of 1944, H.R. 4278. In general this pertains to eradicating animal and plant pests, to fire control, conservation, the orderly marketing of agricultural commodities, the Farm Credit Administration and the Rural Electrification Administration.

All this had nothing to do with medicine until May 2 when Senator Bushfield of South Dakota offered an amendment "that no part of such sums be available for the promotion or aid of any program of medical care which prevents the patient from having the services of any practitioner of his own choice so long as state laws are complied with."

This, if it appears innocent on the surface, was actually an attempt by sectarian healers to enter the medical programs carried on by the Farm Security Administration. According to reliable information it was sponsored by the osteopaths.

Eventually, this amendment failed and the threat has been erased. The bill, as originally set up, without the Bushfield amendment, finally passed. On September 7 Dr. Trueheart sent telegrams to Senators Capper and Reed urging them to oppose the amendment.

Since then answers have been received from both senators which are interesting enough to be repeated.

"Dear Dr. Trueheart: I have received your telegram of September 7, protesting adoption of the Bushfield amendment to H.R. 4278. I am glad to be able to advise you that the section to which you object has been taken out of the bill. That change having been made, I think the act is probably all right.

"It is always a pleasure to hear from you. I will welcome your suggestions at any time. Sincerely yours, Arthur Capper."

"Dear Doctor Trueheart: I have your telegram of September 7. Yesterday the Senate receded from all of the amendments, on this point, which it had written into the bill. I understand this will meet your objection. It should be understood that there are a number of Senators, including myself, who do not favor socialization or federal control over medicine, but who are trying to find some reasonable ground upon which to stand. My own feeling is that eligibility to practice medicine should be left to the states without any attempt to exercise overall federal

control. As long as the practice of medicine is in accordance with the state requirements, I find no reason for federal interference. Once we depart from this principle, socialization of medicine becomes more probable. With my best wishes, I am, Cordially yours, Clyde M. Reed."

MANAGING EDITOR

Miss Pauline Farrell has been selected to become the managing editor for the Kansas Medical Journal to fill the vacancy occurring when Mrs. Mateel Todd resigned to take other employment.

Miss Farrell comes highly recommended and has wide experience in the work she will do for the Journal. For several years she worked on the Kansas Stockman, a monthly trade journal for the Kansas Livestock Association. Before that time she was on the staff of the Kansas Business Magazine.

The Editorial Board welcomes Miss Farrell and invites you to visit her at the executive office, 406 Columbian Building, Topeka. She begins her duties on October 16 and will start, at that time, preparing the November issue.

RED-CELL RESIDUES

The organization and rapid growth in the last three years of the Blood-Donor Service of the American Red Cross has been one of the miracles of this country's ability to produce for war. During the interval between the two world wars it became evident that restoration of blood volume with plasma or serum was the *sine qua non* of the treatment of shock, and the large supply of plasma now available to our armed forces is the result of careful and long-sighted planning.

During the course of World War II interest has been aroused in some of the constituents of the blood other than plasma itself. This has been true of the red-cell residue following the removal of plasma from a blood donation. Soon after the organization of the Blood-Donor Service it became apparent that the loss of red-cell residues was a frank waste of an important part of the donor blood. Furthermore, as experience with war casualties grew, a need for the red-cell component of blood, as well as the plasma, became evident. Red cells have been supplied so far to our troops overseas by whole blood drawn for the purpose at the time and place it was to be used. The use of red-cell residues at the front has been limited by the poor storing qualities, so that even with airborne transportation it has not been practical to use

Red-cell residues have been made available, however, to certain hospitals in the United States for civilian use. Taylor, Thalhimer, and Cooksey report the administration of eighteen thousand transfusions using red-cell residues resuspended in physiologic saline solution. Their work has confirmed, on a much larger scale, the experience of many others who have in recent years shown that suspensions of red cells may, with certain limitations, be used in the treatment of anemia.

The red-cell suspensions so used furnish all the important elements for the replacement of erythrocytes. The chief advantage of their use is that the plasma is saved for other purposes. Another advantage is that, by suspending the erythrocytes in a smaller amount of fluid than that necessary to restore the original volume, a transfusion medium is made that contains less sodium chloride and more hemoglobin than a whole-blood transfusion. This procedure is particularly useful in patients with severe anemia and congestive cardiac failure, in whom it is urgently desirable to raise the hemoglobin and red-cell count and to reduce the blood volume and body salt. Red-cell suspensions made in this way, however, remain usable for a much shorter period of time than those resuspended to their original volume in physiologic saline solution or in one of the newer fluids.

The storage of red-cell suspensions has been studied for a number of years, but research has been greatly stimulated by the quantities now available as well as by the possibility that, with air-borne transportation, the cells might be used by the armed forces overseas if their life in storage could be prolonged. Investigators have been searching for the ideal resuspending fluid—one that would prevent increased fragility of the cells to hypotomic saline solutions, that could be given without fear of untoward reaction and that would, if possible, promote the longevity of the cells after administration. Solutions containing various combinations of electrolytes, and usually glucose, have been extensively studied regarding both the prevention of hemolysis in vitro and the duration of life of the cells in vivo. Denstedt et al., after much painstaking work, proposed a fluid containing 2.3 per cent glucose and 1.7 per cent sodium citrate, buffered to pH 7.4 with sodium phosphate. Using red cells tagged with radio-active iron, Ross and others have found that cells resuspended in Denstedt's fluid, or a similar mixture, can be stored for two weeks, or perhaps longer, with 80 to 90 per cent of the cells surviving for forty-eight hours after transfusion. Although further studies are necessary, this is an indication of the possibilities of the use of red-cell suspensions.

The separation of blood into its physiologically active components offers new opportunities for the blood bank of the future. One might think of each community with a blood-donor service prepared to supply whole blood, plasma, albumin, specific glo-

bulin fractions and erythrocyte suspensions. The proper use of such a service would require the cooperation of the physicians within the community, but the therapeutic possibilities are manifold.—The New England Journal of Medicine, August 17, 1944.

CRIPPLED CHILDREN COM-MISSION

Dr. M. Trueheart, President, Kansas Medical Society, Sterling, Kansas.

Dear Dr. Trueheart:

It has been suggested to me that you, and perhaps the other members of your organization, might be interested in a bulletin on acute poliomyelitis, which was recently sent to the Probate Judges in the State of Kansas. This bulletin was prepared in the office of the Kansas Crippled Children Commission, at the request of the Riley County Medical Society. It states the position of the Commission relative to the treatment of this disease, and explains our desire that such treatment should be a private matter, except in those instances where the parent of the child afflicted cannot afford the cost of private treatment, in which cases, of course, the Commission is very anxious to care for the child.

There are diverse opinions as to the proper treatment of acute polio, and as to the value of the socalled Kenny Method. The Commission is aware of this, and does not feel itself competent to pass upon many of the questions involved. We can say, however, with assurance, that the public in these times is demanding this treatment, and that we believe as long as it is properly administered, and confined to the active period of the disease, it is in no wise detrimental to the child. Further, that we believe the value of this method of treatment in relieving pain is generally accepted, and that it seems to have merit in the preventing of contractures and deformities. We are, therefore, providing it for Commission cases. We would like, however, to make it clear that we do not feel this treatment can take the place of the long accepted remedial measures necessary after the acute state has passed, such as physiotherapy, braces, or surgery wherever recommended. All children treated by the Commission, who are afflicted, receive this care, and we wish to express ourselves as feeling that it is important that it be made available to private patients immediately following the active phase of the disease, in all cases where crippling conditions result.

It does not appear that Kansas will experience a polio epidemic in 1945, but the history of the dis-

ease would make it probable that in years to come these will recur. It has seemed to the Commission that knowledge on the part of the medical profession generally, of the treatment of polio by the most advanced methods available, would be much in the interest of the public. This, it seems to us, would enable many private cases, at least those of a milder character, to be treated in other than the centers where great congestion results in times of epidemic, as was the case in Kansas in 1943. In this connection, it has been suggested to us by physicians that it might be possible for the State Board of Health to train its nurses, and those County nurses coming under its control, in the technique of hot packs, or such other improved treatment as may be developed, and that the University of Kansas Medical School, in co-operation with the State Board of Health, and the Kansas Medical Society, might co-operate in holding courses in the various parts of the State to which practicing physicians could be invited. Such courses would be similar to those previously given in pediatrics and obstetrics under the supervision of the University of Kansas Medical School. The Commission, of course, is not in a position to initiate such a program, but we have felt it might be acceptable for us to mention it to you with the thought that through such a program there might be provided care for private cases of the disease, as it appears in normal times, and that this knowledge, on the part of physicians generally, would be very valuable when the next epidemic comes to Kansas.

We would be much pleased, Dr. Trueheart, if this letter and the bulletin attached, could be given publicity in your Journal, as we are anxious the medical profession of Kansas understand the position of the Commission, and its desire not to encroach in any manner on the private practice of medicine in the State of Kansas.

Sincerely yours,
C. J. Chandler, Chairman,
Kansas Crippled Children Commission.
ACUTE POLIO BULLETIN

The Kansas Crippled Children Commission has received a request from the Riley County Health Department that definite information regarding requirements of eligibility, procedures of commitment, and a list of approved hospitals be sent each member of the Riley County Medical Society. In response to this request the following bulletin has been prepared, and is being sent to all the Probate judges of Kansas, with the thought that it will bring them up-to-date on the situation in regard to the commitment of acute cases of poliomyelitis. There follows a resume of the Kansas law establishing the Kansas Crippled Children Commission, and the additional informa-

tion requested by the Riley County Health Department.

1. A crippled child is defined as one "under twenty-one years of age, unmarried, and of sound mind, afflicted with a hare-lip, cleft palate, congenital cataract or an orthopedic condition or deformity that can be cured or materially improved. The orthopedic condition or deformity referred to above shall include any deformity or disease of childhood generally recognized by orthopedists and by the medical profession as falling within the field of the orthopedic surgeon, and it shall include deformities resulting from burns. It shall not include recent fractures." (The Attorney General of the state has held that the treatment of acute cases of poliomyelitis comes under the law.)

Eligibility is based upon the following requirements:

Six months residence in the county and state by the parent or guardian of the child.

Inability of the parents to pay for care.

Probability that the child can be materially improved.

Soundness of mind.

Existence of a crippling condition as defined by the law.

It is the responsibility of the probate judge to determine eligibility. The statements about the child's physical condition, mental condition, and ability to be improved are made by a physician. The Kansas Crippled Children Commission may assist the probate judge through its Medical Advisory Committee in determining whether the condition is one which may be given care under the law.

2. Either the family or an interested individual, the county health officer or the family physician, who is a resident of the county may make the initial application to the probate court. The judge determines the eligibility of the family in regard to residence and ability to pay for care. He directs the family to take the child to the county health officer, family or other local physician for an examination and submits a Form of Case Report for the physician's convenience in giving necessary medical information. When he receives the report of this examination, a hearing, usually informal, is held and if the physician has recommended treatment for a condition which can be given care under the Crippled Children Law, the judge sends commitment papers to the Commission office.

When acute polio cases are involved and the family physician knows that the family is financially unable to provide for the necessary care and treatment of the child, he may contact the probate judge, fill out the Case Report and explain to the judge the urgency of an emergency. The judge can call the

Commission office for designation of hospital, then clear with the superintendent of said hospital to determine if a bed is available and have the child on its way as soon as possible, submitting crippled children papers to the Commission office after the emergency of getting the child to the specialist and the hospital has been provided for.

The Crippled Children Commission, while extremely anxious to care for all children that should properly come under the law, is very jealous of the position it has always taken, that all cases which can be handled privately, and paid for by the parent, should be thus treated. This is not only the intent of the law, but it is the only manner in which the private practice of medicine can be protected. Further, the Commission has called to the attention of the probate judges over the state that many parents who could not carry the expenses of a long operative orthopedic case are able to provide the care necessary in the treatment of acute polio, this cost being comparable to many other medical expenses which befall the average family.

The facilities of all Commission approved hospitals are at the disposal of private patients, of course, as well as those treated under the Kansas Crippled Children Law. Several of the orthopedic surgeons located in Kansas, who practice privately, and also for the Commission, are now in the military services, and consequently are not available. There are however, it is felt, a sufficient number in the state to take care of both private and public cases of acute polio, and the demands for orthopedic care.

3. At the present time Bethany and the University of Kansas Hospitals, Kansas City, St. Anthony's at Hays, and St. Francis and Wesley Hospitals, Wichita, are available for the treatment of acute polio cases, committed under the Kansas Crippled Children Law. Cases are committed to the nearest hospitals if beds are available there, and, in cases where they are not, or any other unusual circumstance attends, the Commission's office at Wichita should be contacted.

A physician wishing to commit a private case may, of course, use the facilities of the above hospitals. All these hospitals are equipped with personnel and physical equipment to administer the Sister Kenny treatment for acute polio.

During last year's polio epidemic the National Foundation of Infantile Paralysis provided care for a very considerable number of cases in Hutchinson, Topeka and Salina, where physicians and nurses had received training through the endeavors of the Foundation, and otherwise. While the Foundation's funds, like those of the Commission, are used for individuals requiring financial assistance, these facilities at Hutchinson, Topeka and Salina were also available

for private cases. We are advised that private treatment through these facilities is available at Hutchinson at this time. While we understand there is no physiotherapist available at either Topeka or Salina at the present time, there is, of course, always the possibility that local interests may make arrangements in Topeka, Salina, or elsewhere for the care of acute polio cases at some later time in the season, and we hope this may be the case.

The treatment of acute polio is still to be perfected, and the Commission is anxious that the medical profession understand its position that the method of treatment of polio, and all orthopedic conditions, is a decision of the parents and the local doctor in the individual case. Such cases as are committed under the Kansas Crippled Children Law are, of course, put into the hands of the doctor on the staff of the approved hospital, and the care of the child then becomes his responsibility.

FETAL ASPHYXIATION

(Continued from Page 345)

to a point just behind the epiglottis and the arytenoid cartilage. The catheter may then be inserted along the underside of the finger and its tip pushed into the trachea. With the finger behind the arytenoid cartilage, the tip of the catheter is bent forward into the trachea and in this manner, it can be prevented from going down the esophagus. After removing the mucus from the throat and trachea, it is reinserted and artificial respiration begun gently. Only the amount of air that can be held in the mouth without distending the cheeks is pushed into the baby's lungs, repeated about fifteen times or more a minute. The baby's color will then become pink, its heart begin to beat more rapidly and the baby begin breathing by its own effort.

The tracheal catheter has been criticized on the grounds that excessive pressure may cause a pneumothorax, a false passage produced or that bacteria may be forced into the baby's lungs from the mouth. Pressure should be exerted only with the cheeks and not with the lungs. If only a pressure of ten to fifteen mm. Hg. is used, there will be no danger. Some skill is required to quickly pass the catheter and it is best learned on babies that are stillborn or die shortly thereafter, as has long been recommended by De Lee.⁵ It is very difficult to insert a catheter in a baby with all reflexes present because of the lack of relaxation of the muscles of the throat and mouth. A simple mucus trap between the mouth and the catheter will prevent saliva from entering the baby's

In the absence of a tracheal catheter, mouth to mouth insufflation may be used. This has the disadvantage that mucus or meconium will be blown into the baby's lungs rather than be cleaned out first. Pressure of the air entering the baby's lungs cannot be so well regulated and air will be frequently forced into the baby's stomach.

SUMMARY AND CONCLUSIONS

- The various factors producing asphyxia should be eliminated or held to a minimum as far as is possible.
- (2) When asphyxia is present, it should be treated immediately by ventilation of the lungs, and the baby treated conservatively.
- (3) Any baby can be revived by a tracheal catheter that can be revived by any other method.
- (4) Drugs stimulating respiration have little value in the immediate phase.

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A CASE OF COMPLETE ABSENCE OF THE INFERIOR VENA CAVA

(Continued from Page 347)

abnormal persistence of these vessels and the failure of the normal channels to develop. It is unfortunate that we have no history of this cadaver, but judging from his appearance, this abnormal venous circulation was in no way harmful to his physical development. He had lived to past middle life (possibly past sixty) and was a large and wellnourished man.

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There are three still births for every 100 babies born alive, according to the Statistical Bulletin of the Metropolitan Life Insurance Company, and a total of about 75,000 stillbirths a year in the United States. The ratio of stillbirths to live births has reduced by nearly one-fifth in the past decade.-Ohio State Medical Journal.

MEN IN SERVICE

Captain J. W. Manley of Kansas City was a visitor at the executive office on September 29. For some months, Captain Manley had been stationed in England, but is now recuperating from an illness at the Winter General Hospital in Topeka.

The September 2 Journal of the American Medical Society carried the following news story which you may have missed: "The Soldier's Medal was recently awarded to Captain William E. Nunnery 'for heroism at March Field, California, on February 1, 1944, when an army airplane made a forced landing and caught fire. An officer of the combat crew was pinned in this airplane. An explosion of the gas tanks was expected at any minute. Captain Nunnery, who was approximately 300 to 500 yards from the scene of the airplane at the time of its crash, immediately proceeded thereto and on arriving at the then burning airplane heroically and with utter disregard for his own safety assisted in extricating an officer crew member who was trapped and seriously burned." Captain Nunnery was graduated from the University of Kansas School of Medicine, Kansas City, in 1942 and entered the service in July, 1943.

The Shawnee County Bulletin carries the following news: "Captain David E. Gray, of Topeka (son of the late Dr. A. D. Gray), serving as battalion surgeon in France with an infantry regiment, has been slightly wounded in action and awarded the Purple Heart, according to word received from him by his wife, the former Jean Campbell. Captain Gray received a shrapnel wound in the neck, but is getting along fine and attending to business as usual, according to his letter."

Capt. H. L. Songer writes as follows: Dear Sirs: I greatly enjoyed reading the July Journal that arrived this a.m., even though it is two months old. However, mail, cigarettes and other unnecessary items have been a little slow since we started our big push in July.

It is needless to write that as battalion surgeon in U. S. Number 1 Infantry outfit 1 have seen much of Europe since D-day (which I am sure everybody who made the landing wants to forget). However, the most spectacular sight was the great bombing mission that was carried out before our push started in July. There were planes in the air as far as

we could see in all directions, except toward the front, for about twenty minutes.

We were welcomed by the French, but their reception did not compare with that given us by the Belgians. I honestly believe they would have given us their last bite to eat had we needed it.

While still in France, I went back to visit an officer friend in one of the hospitals that was but three miles from the Kansas Evacuation Unit, but I didn't know it at the time. I certainly would have enjoyed seeing the Kansas men again. I haven't seen them since we were in Sicily, just before Col. Hashinger left them.

At present we are comfortably established in a public building that we have turned into an aid station and hospital. It is quite a change compared to tents, dugouts and barns that we have occupied most of the time, but we probably won't be enjoying this luxury long.

My full address is: 2nd Bn., 26th Inf., APO1, c/o Postmaster, New York, N. Y.

Lt. Harold F. Spencer, Garnett, writes: "I would like my mailing address for the Journal changed to a Fleet Postoffice out of San Francisco." Lt. Spencer has recently completed a six months course in anesthesiology in Philadelphia, Pennsylvania, under Dr. Henry Ruth, president of the American Board of Anesthesiology. Clinical work for the course was completed at the University of Pennsylvania hospital, at Temple University Hospital, Hanamannian Hospital, and others. Lt. Spencer has been assigned to an advance base outfit in the Pacific area.

Major M. E. Pusitz, Topeka, now stationed at Camp Haan, California, is the author of an article in the July,



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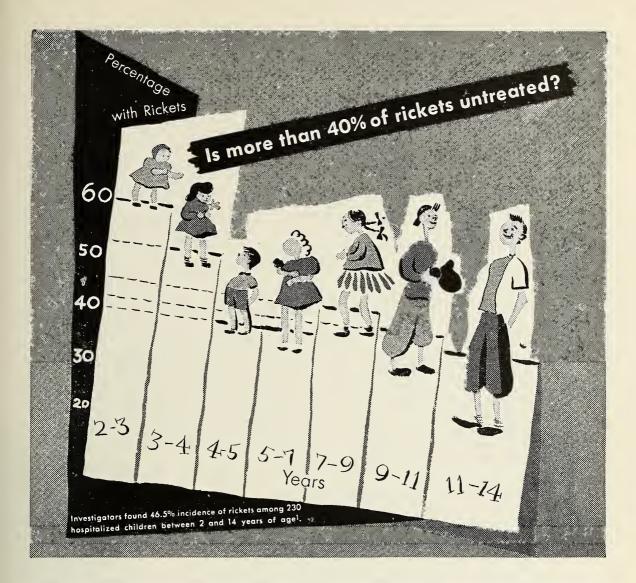
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It used to be thought that rickets is prevalent only in the first two years of life. This was when the roentgenological and clinical manifestations were accepted as the criteria for diagnosis. Recent studies suggest that perhaps as the result of this impression, as much as 40% of rickets has gone untreated.¹

Microscopic examination of the long bones of children between the ages of 2 and 14 who died from various causes showed a startlingly high percentage of cases of rickets in older children. The highest incidence was found during the third year (57%). This suggests the need of continuing vitamin

D supplementation beyond infancy. Evidently, as long as growth persists, and at least through the fourteenth year, administration of vitamin D should be made routine; because even in children who appear healthy, histologic bone studies show that disturbances in calcium-phosphate metabolism are fairly common.

Whether the vitamin supplements prescribed are for infants or for older children, Upjohn preparations may be given routinely with the assurance of dependable potency in pleasant, easy-to-take dosage forms.

1. Follis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.; Am. Jrl. Dis. Child. 66:1 (July) 1943. Note: A reprint of this paper is being mailed to all physicians. Additional copies are available upon request.



1944, Journal of Bone and Joint Surgery, entitled "Bone-Drilling in Delayed Union of Fractures." The article deals with experiences of an orthopedic surgeon in Army service.

Major Cecil E. Petterson of Norton is a flight surgeon with a 15th Army Air Force B-24 Liberator Bombardment Group, based in Italy. A recent newspaper release told that the unit recently was awarded the Distinguished Unit Citation for its feat in destruction of the railyards at Bucharest, Romania. Major Petterson, who is a graduate of Washburn University and the University of Kansas School of Medicine, entered service on August 9, 1941, and was sent to Italy last December. Before entering the service, he was a member of the staff of the Norton Tuberculosis Sanitarium. Captain C. A. Petterson, a brother, is serving in the Medical Corps in New Guinea, and another brother, Perry Petterson, will receive his M.D. degree from the University of Kansas Medical School in October.

The following transfers have been reported during the past month:

Capt. A. C. Armitage of Kansas City from Chanute Field, Illinois, to Las Vegas, Nevada.

Comdr. B. J. Ashley, Topeka, to an FPO address out of San Francisco, California.

Capt. R. E. Baldridge, Kingman, to the 100th General Hospital, APO, New York.

Major C. E. Basham, Eureka, from the 34th General Hospital, Los Angeles, to Atlantic City, New Jersey.

Lt. John S. Betz, Kansas City, to the Army Air Base Hospital at Alliance, Nebraska.

Lt. Clovis Bowen, Valley Falls, from Dalhart, Texas, to a combat training school at Ardmore, Oklahoma.

Capt F. W. Buooa, Mulvane, Davenport, Iowa, to an APO out of New York.

Capt. M. W. Carlson, of McPherson and Ellinwood, who has been overseas twenty-one months, to an APO out of New York.

Capt. R. C. Clapp, Wichita, from Santa Barbara, California, to the Presidio, San Francisco.

Capt. Charles T. Frey, Wichita, to the 166th General Hospital, APO, New York.

Major P. E. Hiebert, Kansas City, to Camp Bowie, Texas. Capt. Max E. Kaiser, Ottawa, to an FPO out of San Francisco.

Capt. C. R. Kempthorne, Manhattan, to an APO, New York.

Major Donald A. Kendall, Great Bend, to the staff at Winter General Hospital, Topeka, Kansas.

Lt. Comdr. B. I. Krehbiel, Topeka, to the U. S. Naval Hospital at Great Lakes, Illinois.

Major R. J. Lanning, Junction City, from Fort Riley to Camp Shelby, Mississippi.

Capt. J. T. Marr, Sterling, from Camp Gordon Johnson to Daytona Beach, Florida.

Lt. M. D. McComas, Courtland, from Fort Benjamin Harrison, Indiana, to Brooklyn, New York.

Capt. Willis H. McKean, Kansas City, from Valley Forge General Hospital, Phoenixville, Pennsylvania, to an APO out of San Francisco.

Capt. L. B. Mellott, Bonner Springs, to Portland, Oregon.

Capt. Philip W. Morgan, Emporia, from Kelly Field, San Antonio, Texas, to Camp Ellis, Illinois.

Lt. E. G. Neighbor, Kansas City, from Orlando, Florida, to an APO out of San Francisco.

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October 23, 24, 25, 26, 1944

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O. THERON CLAGETT, M.D., Surgery, Mayo Foundation.

CHARLES C. DENNIE, M.D., Dermatology, University of Konsas School of Medicine.

LAWRENCE P. ENGEL, M.D., Surgery, University of Konsas School of Medicine.

GEORGE P. GUIBOR, M.D., Ophtholmology, Children's Memorial Hospitol, Chicago, Illinois.

TINSLEY R. HARRISON, M.D., Medicine, Dean, Southwestern College of the Southwestern Medical Foundation.

HAROLD O. JONES, M.D., Gynecology, Northwestern University Medical School.

RALPH A. KINSELLA, M.D., Medicine, St. Louis University School of Medicine.

HUGH McCULLOCH, M.D., Pediatrics, Washington University School of Medicine,

RALPH H. MAJOR, M.D., Medicine, University of Konsos School of Medicine.

WILLIAM F. MENGERT, M.D., Obstetrics, Southwestern Medicol College of the Southwestern Medical Foundation.

ALAN R. MORITZ, M.D., Pathology, Harvard Medical School.

HENRY H. RITTER, M.D., Surgery, New York Postgraduate Medical School and Hospital, Columbio University.

GEORGE E. SHAMBAUGH, JR., M.D., Otoloryngology, University of Illinois College of Medicine.

JAMES S. SPEED, M.D., Orthopedic Surgery, University of Tennessee College of Medicine.

BRUCE K. WISEMAN, M.D., Medicine, Ohio Stote University College of Medicine.

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BLANCHE WHITE 401 1st National Bank Bldg. Dodge City, Kansas BEULAH GALATAS 433 South Market St. Wichita, Kansas Tel. 3-3510 Major Garth S. Ortman, Kansas City, who formerly had an APO address out of San Francisco, to Glendale, California.

Capt. Andrew E. Rueb, Salina, from El Paso, Texas, to Seattle, Washington, and probably to an APO out of New York, with the 6th Field Hospital.

Capt. E. J. Schulte, Kansas City, from Camp Barclay, Texas, to Fort George Meade, Maryland.

Capt. L. F. Steffen, El Dorado, to the 126th General Hospital, Longview, Texas.

COUNTY SOCIETIES

At a meeting of the Allen County Medical Society held in Iola, Dr. A. R. Chambers of Iola was elected secretary of the organization to fill the unexpired term of office of Dr. Cora Crews who recently moved to Hiawatha.

The Central Kansas Medical Society held a meeting in Hays on September 14. The afternoon program speakers were: Dr. J. L. Lattimore, of Topeka, and Dr. Harold Jones, of Winfield. The society and Auxiliary to the society held a dinner at 6:00 at the Lamer hotel and Mr. Hugh Burnett, of Hays College, was the dinner speaker.

The Cowley County Medical Society held a meeting in Winfield on September 21.

At a meeting of the Rush-Ness County Medical Society

held in LaCrosse on September 11, the following officers were elected: Dr. W. J. Singleton, of LaCrosse, as president; Dr. J. E. Attwood, of LaCrosse, as secretary-treasurer.

The Shawnee County Medical Society held a meeting in Topeka on September 4. Members of the surgical staff of Winter General Hospital were the guest speakers and the program for the meeting was as follows: "Fascia Lata Pedicle Graft in Repair of Large Hernial Defects," Lt. Col. Warner F. Bowers; "Use of Curare in Anesthesia," Captain Mario L. Garofalo; "Pilonidal Sinus—With Especial Reference to Surgical Failures," Captain Wm. H. Ellett; "Skin Grafting in the Treatment of Burns," Major Joseph G. Kostrubala; and "An Anatomical Method of Hemorrhoidectomy," Major Dudley R. Smith.

The Stafford County Medical Society held a meeting on August 9, in St. John. Dr. C. S. Adams of St. John was re-elected president, and Dr. J. C. Ulrey was re-elected as secretary-treasurer of the organization for 1944-1945.

The Wyandotte County Medical Society held a meeting in Kansas City on September 19. Previously these meetings have been held in the Chamber of Commerce rooms, but the meeting place for the organization will be 619 Ann Avenue in the future. This is the location of the City-County Health Department Building. Dr. H. W. King of Kansas City spoke on "Acute Obstructive Cholecystitis" and Dr. F. H. Foley of Kansas City spoke on "Industrial Medicine."



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On Tuesday, November 7, you are invited to cast your ballot in a general election. At a time when many parts of the world have no chance to vote, our privilege becomes especially noteworthy.

We have a voice in selecting officials to direct our government. Our choice is free. We suffer no coercion nor is our expression dictated or controlled in any way. This year we mark this privilege as symbolic of the things for which America was founded. It represents our strength and becomes an ideal that somehow is worthy of our lives.

On a state-wide and local basis the election means many things. The coming vote may well determine the course of medicine in Kansas for a long time to come. This issue, striking so directly at the center of our every day lives, gives us now, more than ever before, a personal interest in the election.

It is not only a privilege but at the present time a solemn duty to add our choice to the final score. If we forget November 7 on that day we will have occasion to recall it many times thereafter.

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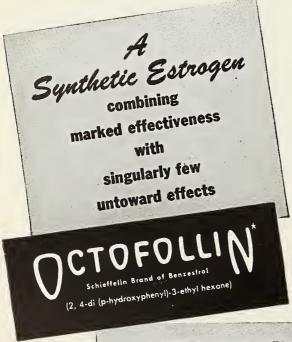
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NEWS NOTES

MEMBERS

Dr. J. R. Rupp, of Liberal, has recently located in Russell.

Dr. P. F. Theis, of Jetmore, has located in Hugoton.

Dr. Cora Crews has moved from Iola to Hiawatha.

Dr. F. C. Beelman, secretary and executive officer of the Kansas State Board of Health of Topeka, is the author of an article entitled "When Hospitals Can Be Built Where They Are Most Needed — Kansas Will Be Ready," in the September, 1944, issue of Hospitals, the official Journal of the American Hospital Association.

Dr. H. C. Ulrey, of Parsons, formerly located in Hepler and Girard, has located in McCune.

Dr. G. H. Penwell, of Russell, has moved to Modesto, California, where he will practice.

Dr. Alvin Y. Wells, of Moline, has moved to Winfield, where he will be connected with the Winfield Hospital.

Dr. John E. Hewett, formerly of Wakefield, and for a time in a government hospital in California and Oklahoma, has located in Riley.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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Dr. Carlton H. Lee, formerly of Pleasanton, and for a time in military service, has located in Stockton. Dr. Lee held the rank of a captain while in the Army and served sometime overseas.

SECRETARIES AND EDITORS ANNUAL CONFERENCE

The Annual Conference of Secretaries and Editors will be held in Chicago, on Friday and Saturday, November 17-18, 1944. The tentative program for the meeting in brief is as follows: State Journals as Moulders of Opinion—As Advertising Media—As News Service; State, Political and Social Trends in our Journals (affecting medical affairs). On Friday, November 17, a dinner meeting will be held at the Palmer House. Dr. W. M. Mills, of Topeka, the editor of the Journal; Dr. F. R. Croson, of Clay Center, secretary of the Society, and Mr. Oliver E. Ebel, executive secretary, will attend the meeting as the Kansas representatives.

ANNOUNCEMENTS

The American College of Surgeons has cancelled its annual clinical congress, which was to have been held in Chicago on October 24 to 27. According to an announcement received from Irvin Abell, M.D., all present officers, regents, governors and standing committees will continue in office.

The 52nd annual meeting of the Association of Military Surgeons of the United States will be held November 2-4, at the Hotel Pennsylvania in New York City. A "Symposium on War Surgery" will be one of the main events of the meeting and will be conducted by leading Army and

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Navy officers. Other features of the meeting will be military and commercial exhibits, under the direction of the Second Service Command Laboratory, medical motion pictures and special "Army" and "Navy" nights.

DEATH NOTICES

Dr. Thomas F. Brennan, 39 years of age, died on August 26, at his home in Ness City. He was born in Butte, Montana, on February 19, 1905, and was graduated from the Creighton University School of Medicine in 1929. He had served in several offices of the Rush-Ness County Medical Society and was its president at the time of his death.

Dr. Robert Samuel Edwards, 78 years of age, died on September 5, of cardio-vascular complications, at his home in Cedar Vale. He attended Bennett College of Eclectic Medicine and Surgery and was graduated from Loyola in Chicago. His widow Estelle Edwards is also a physician. At one time he practiced in Lakin. He was a member of the Chautauqua County Medical Society.

Dr. Albert G. Smith, 84 years of age, died on September 25, at his home in Oskaloosa. He came to Topeka in 1864, and was graduated from the University Medical College of Kansas City in 1886, after which he practiced in Thompsonville for two years and then moved to Oskaloosa where he lived for fifty-two years. He was an honorary member of the Shawnee County Medical Society.

Dr. Dowdal Henry Davis, age 60, died at his home in Independence on September 28. Dr. Davis was born in St. Louis. He graduated from the Howard University Medical School in Washington, D. C., and had been pracThe Neurological Hospital, 2625 The Paseo, Kansas City, Missouri. Operated by the Robinson Clinic, for the care and treatment of nervous and mental patients and associated conditions.



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ticing in Independence for thirty-seven years. Death came as a result of a heart attack.

Dr. Ivan B. Parker, age 73, of Hill City, died at his home on October 4. Dr. Parker was born in Manchester, Iowa. He received his medical education at the University Medical College of Kansas City, and had practiced in Graham County for fifty years.

DISTINGUISHED MEDICAL OFFICERS HONORED AT WINTER GENERAL HOSPITAL

Winter General Hospital, U. S. Army hospital in Topeka, Kansas, has adopted the interesting plan of naming its important clinics, buildings and streets for distinguished deceased medical officers of the Army who so far have never been honored by having their names given to buildings, general hospitals, or other entities of the Medical Department, U. S. Army.

The names are selected as appropriate for the particular clinic or building. The names of the streets are those of medical officers who have become the heads of other branches of the Army.

The following are the names so far selected:

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Named for Major William Williams Keen (1837-1932) of Pennsylvania, pioneer student-with his colleagues, Acting Assistant Surgeons Silas Weir Mitchell and George Reed Morehouse-of gunshot wounds of nerves; one of the few medical officers who served in both the Civil War and the first World War.

The Rush Neuropsychiatric Clinic

Named for Surgeon General Benjamin Rush (1745-1813), of Pennsylvania, author of the first American book on insanity, the only systematic American treatise on the subject before 1883; signer of the Declaration of Independence; founder of the University of Pennsylvania.

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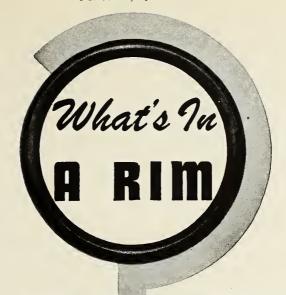
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AUXILIARY

PRESIDENT'S MESSAGE

The fall State Board meeting was held in Salina, September 27-28. Thirty-nine members of the Board were present which represents a splendid attendance. Your president is most grateful to all who came here in spite of the inconvenience of travel plus rain. All six elected officers, thirteen past presidents, four councilors, all state chairmen except two, and seven county presidents were present.

The first evening, the Board members were dinner guests of the Saline County Medical Auxiliary at the home of Dr. and Mrs. L. S. Nelson. Mrs. C. D. Armstrong and Mrs. C. M. Fitzpatrick, president and vice-president of the local auxiliary were chairman of the evening's program. Dr. Nelson, second vice-president of the Kansas State Medical Society extended greetings and gave a short discussion of medical problems due to the war. Dr. E. M. Sutton greeted the guests in the name of the Saline County Medical Society. Also on the program was a musical number by a high school trio and a review of "Why Women Cry," by Mrs. A. Louis Lyda.

The second day the official business meeting of the Board was held at my home. Reports were given by all officers, chairmen, councilors, and county presidents. Your president reported on the National Convention held in Chicago in June. The plans of the State Chairmen have been approved by the Advisory Council and will be mailed to the county auxiliaries very soon. Mrs. Beelman, state Bulletin chairman, reports sixty-five Bulletin subscriptions so far—

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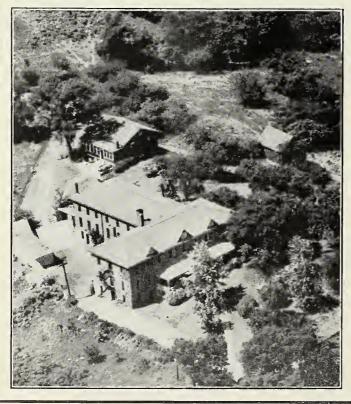
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let's hurry and purchase our text-books. Mitchell County reports one hundred per cent Bulletin subscriptions; Shawnee County reports an increase of nineteen members over last year's membership; Central Kansas auxiliary is subscribing to HYGEIA magazine for the USO's in their communities. The other auxiliaries will have their first meetings in October. The councilors will concentrate their efforts on members-at-large and encourage them to read the Bulletin and place two HYGEIA subscriptions in public places.

Following the business meeting all out-of-town guests and Saline County Auxiliary members were luncheon guests of your president at the Country Club. An impressive candle-lighting ceremony in honor of the past presidents was presented by Mrs. E. M. Sutton of Salina. A radio skit "Let's Be a Member of the Medical Auxiliary," by the dramatics department of Marymount College and two violin numbers by Mr. Ben Vandervelde, Kansas Wesleyan, completed the program.

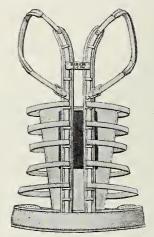
Each member returned home with this message: Coming together is a beginning, keeping together is progress, working together is SUCCESS.

PUBLIC RELATIONS

Our problem of public relations for the Auxiliary is one of understanding the problems and attitudes of our community, state and nation with regard to health. It is also one of understanding the position of the AMA concerning these problems, that we may maintain a profound and lasting confidence in American medicine, the achievements of which have given us the highest standards of medical service in the world.

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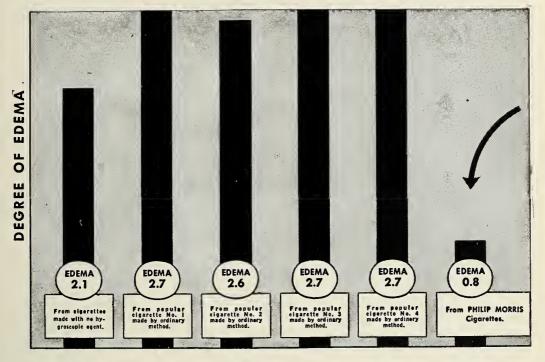
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*N. Y. State Journ. Med. 35 No. 11,590 ** Laryngoscope 1935, XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

I suggest the following program for the public relations section of the Auxiliary:

- 1. Promotion of health education among lay groups.
 - a. Education is a slow process and its results are not obtained quickly. Let us work along with the Hygeia committee encouraging each auxiliary member to be a thorough Hygeia reader as a means of self instruction, therefore a means of dissemination of knowledge to the public.
 - Plan a Public Relations meeting for the laity; providing speakers from Medical and Health associations.
 - c. Stories of Medical paintings, medical historical lore, medical discoveries and stories of heroes of wars all make fascinating programs for lay clubs. These can be presented to study clubs, PTA groups, church organizations, service clubs, civic groups and a group or organization that has or may have a health program. Each member of an auxiliary is a health missionary, impress upon her the responsibility of being a good one.
- Promotion of Nurses' Aide and Authentic Nutrition programs.
 - a. Groups to be taught by auxiliary members.
 - b. Groups to be formed by auxiliary members.
 - Representative from local membership on the community committee.
- 3. Promotion of child health and care.
 - a. Sponsor clinics for child health.
 - Contribute time for personal services as an auxiliary at any child center for child care of working mothers, or child clinic.
 - Donations of materials and supplies for Child Centers.
- 4. Radio Programs.
 - a. Promote interest in national and local radio broadcasts.
- Promote auxiliary cooperation in all forms of Defense and War activities.
- 6. Practical help to medical families in service.
 - Include wives of physicians in army centers in your community in local activities.
 - -Mrs. Charles M. Jenney, State Chairman.

LABETTE COUNTY

The Labette County Medical Society auxiliary met with Mrs. M. C. Ruble in her home at Parsons, September 20, 1944, with eight members present. Mrs. Guy W. Cramer gave an interesting paper on "Post Graduate Education" (especially for doctors after war who are now in service).

During the business meeting Mrs. J. A. Ebert, Oswego, presided.

Mrs. G. W. Hay was nominated to fill the vacancy of secretary-treasurer caused by departure of Mrs. C. E. Hardin to California to make her home.

Year books were distributed and the president gave each member a list of the committees that she had appointed.

A sympathy card was sent to Mrs. G. L. Maser since the death of her mother, September 7.

Suggestions were made for some sort of hand work that we might do during our meetings during the coming months such as the making of bandages, dressing, etc.

Suggestions were also made for a dinner meeting to be held possibly at the home of one of our members for the doctors and wives some time this Fall.

Refreshments were served by the hostess during the social hour.

NEWS

Mrs. Guy W. Cramer is employed as teacher of speech and English in Parsons schools. Her husband Captain Cramer is in service in the south Pacific.

Mrs. M. C. Ruble reports that her father is not improving and has been ill for several months. He is Bert Dunn of Independence, Kansas.

Dr. and Mrs. F. P. Dwiggins have returned from a months vacation to Texas and California. Dr. Dwiggins is chief of the staff of physicians at the Kansas Ordnance Plant located near Parsons.

The Central Kansas Medical Auxiliary held its quarterly meeting at Hays, Kansas, on September 14, 1944. There were ten members present and one guest, Mrs. Trueheart, wife of the president of the Kansas Medical Society. A special project was planned, that of placing the magazine Hygeia in the USO in Russell and Hays.

KANSAS MEDICAL ASSISTANTS' SOCIETY

EXECUTIVE COUNCIL MEETING

The fall meeting of the Executive Council of the Kansas Medical Assistants' Society was held in Kansas City on September 3. The following members were present: Zura Crockett, of Wichita; Marjorie Euler, of Topeka; Carmen Kline, of Kansas City; Margaret Provost, of Strong City; Adena Miller, of Ellsworth; Edna Nichols, of Hutchinson; Faye Bullard, of Hutchinson; and Dr. L. B. Spake, of Kansas City.

Summarizing the business completed the following action was taken: changing of time of dues, appointment of Florence Linton, of Topeka, as General Membership Chairman (her committee of membership to be composed of the councilors from each district). Consideration of a National organization of the same nature and aims and request that the Society Executive Secretary correspond with other state societies regarding same; revision of the secretary's book to include additional pertinent material of society interest; and possibility of a Scrap Book for organization clippings of interest. No decision was made on time of next state meeting but meeting was to be held in conjunction with the Society state meeting and if possible preceding that meeting.

The Sedgwick County Medical Assistants had a program of special interest at their August meeting at which time Dr. J. P. Berger, dermatologist, gave an informal discussion with Kodachrome of some dermatological conditions of special interest.

The Reno County Medical Assistants' Society held a meeting at the Wiley Tea Room in Hutchinson on September 12. Miss Lorna McPeek, physical therapist of Grace Hospital gave a talk on "Poliomyelitis and the Kenny Treatment." The next meeting will be held on October 10.

The Sedgwick County Medical Assistants' Society had its regular monthly dinner at the Allis Hotel. A large attendance, including many new girls, were present. Dr. Claude Tucker showed a very educational film which was shown at the National Convention in Chicago. Dr. Hal Marshall also showed some films on lighter subjects, which were greatly enjoyed.

Zura Crockett and Charlotte Parrish attended the State Officers and Counselor meeting in Kansas City.

THE JOURNAL of the

KANSAS MEDICAL SOCIETY

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Volume XLV

NOVEMBER, 1944

Number 11

THIOURACIL IN THE TREAT-MENT OF HYPERTHY-**ROIDISM**

(Six Cases)

Robert E. Bolinger, M.D.*

Kansas City, Kansas

The clinical use of thiouracil in the treatment of hyperthyroidism is unique in that it is apparently the first example of a synthetic drug which actually specifically depresses the action of an endocrine organ. Furthermore, it is another interesting example of a clinically useful drug which evolved from the extensive reservoir of experimental biology and medicine. Indeed, twelve years ago the first references to this subject were relegated to the abstract and considered only incidental to the main problem, i.e. etiology of goiter. These references were concerning an epidemic of goiters4 in laboratory rabbits, the cause of which was found by Webster9 to be the large amount of cabbage in the diet. The effect was independent of the iodine content. A conjecture at this time, later contradicted, was that a cyanide in the cabbage was the active agent, causing a depression of tissue metabolism and compensatory hyperplasia of the thyroid tissues. In 1938 it was shown by Sharpless⁸ that a similar condition could be produced by feeding a soybean diet, and later the range of goitrogenic foods included all of the Brassica seed vegetables. Attempts to show similar effects by pure chemicals were then undertaken. Enlargement of the thyroid was produced by feeding sulfaguanidine to rats⁵ and also by feeding phenylthiocarbamide^{6,7}.

Systematic investigation of these drugs and their properties was undertaken in 1943 by Astwood². An important feature of his work was the emphasis on the systemic effects of these drugs, showing a definite decrease in rate of oxygen consumption and metabolism. The old idea of depression of tissue

metabolism then became untenable, because the metabolic depressant effect was reversed by feeding desiccated thyroid. The drug having the most powerful depressant effect was 2-thiouracil (2-thio-6 oxypyrimidine). Other substances which were active were thiobarbituric acid, aniline, sulfa drugs and thiocyanates.

It was also found that iodine would reverse the metabolic depressant effect in some and not affect it in others. Thiouracil belonged to the latter group.

In 1943 Astwood¹ reported the first cases in which the drug was used clinically. There were three cases, all showing an abrupt reduction in metabolism to normal or below and marked relief of symptoms. The only toxic manifestation was a transient leukopenia relieved by withdrawing the drug. Nine cases were reported by Williams and Bissel¹⁰. These also showed a very favorable response. In most of these cases surgery was not used. Eleven cases were reported by Bartels³ in which the drug was used preoperatively.

In our clinic the drug has been used on several cases selected at random, and six of these are described below. In several of our cases here we have combined x-ray irradiation of the gland with the drug. This we believe aids greatly in reducing the actual size of the gland.

CASE REPORTS

Case I-E.W., a fifty-seven-year-old white male, treated as an out-patient (chart 1). The patient's history dated back to 1937 when he had loss of weight, palpitation, shortness of breath, and some swelling of the ankles. Exophthalmus was present at that time and also a large goiter. At that time in another clinic he was diagnosed as exophthalmic goiter and placed upon Lugol's solution and digitalis. He improved to some extent, but after some time his symptoms recurred and became progressively worse until he was seen here February 5, 1944. At that time he was edematous, dyspneic, and totally unable to work.

Physical examination revealed a typical exophthalmus and marked diffuse goiter. Obvious dyspnea and edema were present. Pulse rate was 100 and BMR was plus 48. Weight was 150. Electrocardiogram at that time showed an inversion of the T wave

^{*} From the Department of Internal Medicine, University of Kansas School of Medicine, Kansas City, Kansas, with the assistance of Ralph H. Major, M.D., Graham Asher, M.D. and Galen M. Tice, M.D.
NOTE—The author also wishes to express his appreciation to the Lederle Laboratories for their kind cooperation in supplying an adequate amount of the drug.

in leads 1 and 4-F, and a depressed ST take-off in lead 2.

The patient was started on thiouracil, 0.6 gram daily. X-ray therapy was started and a total of 744 RU given until March 15, 1944. In about a week there was a distinct improvement in the symptoms although the patient was ambulatory. On February 15, 1944, the BMR was plus 40 and the pulse had fallen to 80.

On February 25 the BMR was plus 30. By March 15 the BMR was plus 5 and the pulse was 70. Weight had gone to 170 pounds. The patient was relieved of his symptoms and able to return to work. The goiter itself had decreased to about thirty-five per cent of its original size. The electrocardiogram on April 18 showed an upright T wave in all leads and a normal ST take-off in lead 2.

The patient at present is on 0.2 gram of thiouracil daily and doing very well. He was treated as an out-patient at all times.

Case II—G.K., a twenty-eight-year-old white female seen as an out-patient on January 15, 1944 (chart 2). This patient had been complaining of nervousness, palpitation, and loss of weight of gradual onset.

Physical examination revealed a moderate amount of exophthalmos and a diffusely enlarged thyroid. Pulse was 120; blood pressure, 160/90; BMR, plus 58; weight, 118 pounds. The electrocardiogram showed some depression of the ST take-off. The patient was started on 0.8 gram of thiouracil daily and small doses of calcium iodide. Within ten days the patient felt better. On February 15, 1944, her findings were as follows: pulse, 105; blood pressure, 140/70; BMR, plus 45; weight 130 pounds.

On March 15, 1944, she felt practically well and her findings were: pulse, 90; blood pressure, 145/70; BMR, plus 30; weight, 135 pounds. Her goiter had decreased some, but not enough, so x-ray treatment was started as in the above patient. The dosage of thiouracil was cut to 0.3 gram daily. By April 15, 1944, the patient felt entirely relieved of her symptoms and complained of gaining too much weight. Her pulse at that time was 80; blood pressure, 130/70; BMR, plus 12; weight, 139.5.

This patient is still being followed and is on 0.2 gram of thiouracil daily.

Case III—G.V., forty-seven-year-old white male, admitted to the hospital on May 16, 1944. Symptoms began three years prior to admission with weakness and nervousness, which became progressively worse until admission. He had loss of thirty pounds of weight and experienced palpitation of the heart.

Physical examination revealed moderately severe exophthalmus, a tremor, and large diffuse goiter. Orthopnoea was present. There was auricular fibril-

lation. Pulse rate was 100 and the cardiac rate was 118; blood pressure was 140/80; BMR, plus 61; weight, 124; cholesterol, 188 mg. per cent.

The patient was then given thiouracil, 0.4 gram daily, and little improvement was seen until the dosage was increased to 0.6 gram daily on May 20, 1944. On May 27, 1944, the findings showed BMR to be plus 39; pulse, 72, but still fibrillating; cholesterol was 230 mg. per cent. At this time he felt much better and there was a definite reduction in exophthalmus and tremor. On June 5, 1944, the patient showed a pulse which was still fibrillating but at a rate of 80 and no pulse deficit. BMR then was plus 30 and cholesterol was 232 mg. per cent. Little change in weight was observed. X-ray to the thyroid was started on June 1, 1944.

This is a fairly resistant case but has shown definite improvement.

Case IV.—C.S., twenty-nine-year-old white female, admitted to the hospital. Her complaint was nervousness, loss of weight and a "pop-eyed" expression. She had experienced these symptoms for about a year.

Physical examination revealed an apprehensive female with severe exophthalmus and moderate diffuse enlargement of the thyroid. Tremor was present. Pulse was 135, BMR was plus 59. Weight changes were insignificant.

She was placed on 0.6 gram thiouracil daily on March 20, 1944. On April 3, 1944, her pulse was 105 and the BMR, plus 38. She was feeling much better. On April 10 she had a pulse of 90 and a BMR of plus 33. The patient went home and in the meantime ran out of the drug. She came back a month later for operation, having been out of the drug for ten days. Her condition was essentially the same as when she left. She was operated on with an uneventful recovery.

Case V.—L. T., sixty-five-year-old white female, admitted to the hospital on May 21, 1944. Her complaint at that time was chronic arthritis of about ten years duration and nervousness which began about four years ago. The nervousness described was characterized by a tremor of the hands and inability to sleep. She had had some dyspnea on exertion and some ankle edema, which was present at the end of the day.

Physical examination revealed a fairly well nourished white female who was not acutely ill. The head was essentially negative. Examination of the neck revealed that the left lobe of the thyroid was enlarged, firm and freely movable; this enlargement measured about six cm. by two cm. Examination of the chest revealed that the heart was normal in size and had a systolic murmur at the base, transmitted into the neck. Blood pressure was 155/85. About a

one plus edema of the ankles was present. The pulse on admission was 120. Basal metabolic rate was plus 46. The patient was found to be a mild diabetic. A diagnosis of toxic nodular goiter was made, and it was advised that she have the adenoma removed. However, the patient was adverse to this, and the following regime of treatment was instituted: She was given small doses of digitalis, not to produce complete digitalization by any means, and was placed on thiouracil, at first 0.1 gram three times a day, and in three days this was increased to 0.1 gram six times a day. She was given no iodide and only small doses of phenobarbital as supportive treatment.

On May 31 the patient was dismissed from the hospital. At this time her basal metabolic rate was plus 20 and her average pulse rate was about 85. Clinically she had improved greatly, there was no dyspnea present, and the ankle edema had subsided. The follow-up study on the patient approximately a month later revealed that she was feeling even better and had had no recurrence of her symptoms at all. At this time she was ambulatory and had been taking doses of thiouracil ranging between 0.3 and 0.6 gram daily. Basal metabolic study done in another laboratory at this time showed little change.

Case VI—W.J., twenty-year-old colored female, admitted to the hospital on June 5, 1944. Her complaint at that time was nervousness, weight loss, with ravenous appetite and dyspnea. Her illness started about two months before admission, with a weight loss which was present in spite of a ravenous appetite. She became nervous and could not stand small noises; she was restless and could not sit still. She had some shortness of breath in bed. She had developed a dry, hacking cough in the two weeks before ad-

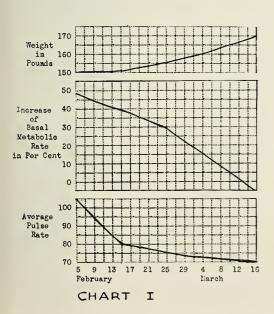
mission, had lost twenty-eight pounds during the past two months, and had noticed a large mass in the neck.

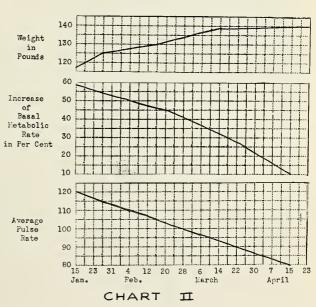
Physical examination revealed an emaciated colored female who appeared to be very nervous. Her eyes showed a moderate amount of exophthalmos. Head was otherwise normal. In the neck there was a firm, movable, non-tender thyroid, enlarged to about three times the normal size. Both lobes were enlarged equally. Examination of the heart revealed a rapid rate and a functional systolic murmur at the apex. No other abnormalities were found here. The abdomen and extremities were essentially normal. The tremor of the hands was very fine and not related to intention. Mosenthal test was done on the patient and revealed poor concentration and poor elimination of the fluid. Also, her cholesterol was 328. It was felt that this, in connection with the increase of slight ankle edema and the poor results of the Mosenthal test, would indicate the patient had some degree of chronic glomerulonephritis. In addition, the x-ray findings revealed a minimal amount of tuberculosis in the apex of the lung, the activity of which is not considered to be very great.

Her basal metabolic rate on admission was plus 61, and her pulse was 130. Her weight at that time was 107. The patient was started on thiouracil and given 0.8 gram of the drug daily in divided doses. She was also given phenobarbital and Lugol's solution.

On June 12 her basal metabolic rate had fallen to plus 36. At this time the patient's weight was 106 pounds, and her general condition seemed to be a little better. However, she was still very toxic. Her pulse had shown no improvement at this time. On

(Continued on Page 390)





UNCOMMON PARALYSIS OF EXTRA-OCULAR MUSCLES*

Byron J. Ashley, Comdr. M.C., U.S.N.R.

Topeka, Kansas

The following reports are of three different and rather unusual cases of paralysis of the extra-ocular muscles appearing in patients in a United States Naval Hospital.

CASE HISTORY

Case I—Bilateral Paralysis of the Internal Recti Muscles with Retention of Convergence: C.E.P. white male—age twenty. Subject was injured in an airplane accident on April 19, 1944. He was unconscious for two and one-half weeks following

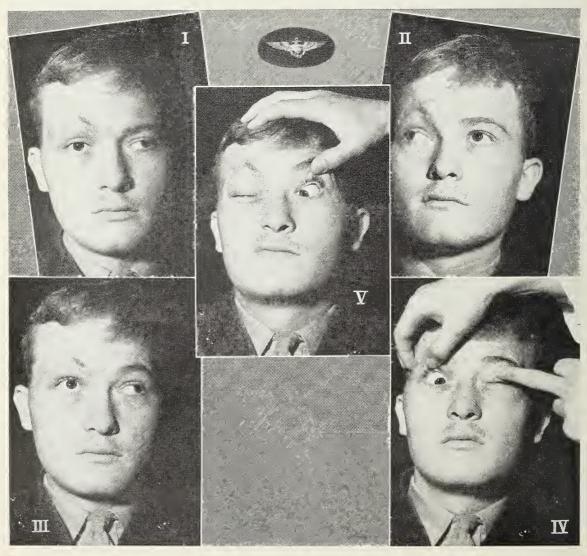
* Publication approval granted. The opinions contained herein are those of the author and are not to be construed as those of the Navy or of the Navy Service at large.

the injury. His previous health had been good as shown by the fact that he had passed the regular physical examinations required of pilots.

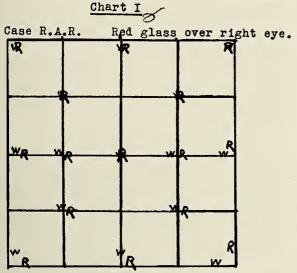
The ocular findings were practically the same when examined on May 8, 1944 and May 22, 1944. His vision was—O.D. 19/20, near vision 14/14; O.S. 20/20, near vision 14/14. The pupils were equal and regular, and both reacted to light and near. There was a divergent horizontal strabismus of about 40 degrees. (Fig. I) He could fix with either eye.

In attempting to look to the right with both eyes, the left eye would not turn in past the midline. (Fig. II) Upon looking to the left, the right eye failed to turn past the midline. (Fig. III) This showed a loss of adduction in conjugate parallel movement.

When the right eye fixed an object at four feet,



the left being closed, the right eye would not turn in past the midline, either on following to the left or on being directed to look to the left. When he fixed on an object four inches away, the right eye turned in almost to the inner canthus as the object was moved to the left. This is illustrated in Fig. IV where he is looking at his nose. The same findings were noted when he fixed with left eye and closed the right.



(Fig. V) This indicates that convergence is still present.

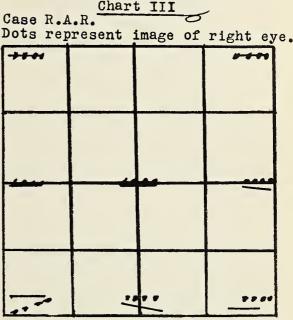
Bielschowsky, in his lectures on motor anomalies of the eye, states that the lesion causing such a condition is in the posterior longitudinal bundle, just above the third nucleus.

Case II—Loss of Convergence: P.P.M. White male—age thirty-five. Was admitted to the hospital February 11, 1944, with diagnosis of cerebrospinal meningitis. He was treated with penicillin. During Chart II

an otherwise normal convalescence, he noticed inability to use the eyes for close work.

Ocular examination revealed: Vision O.D. 20/20, near vision 14/14; O.S. 20/20, near vision

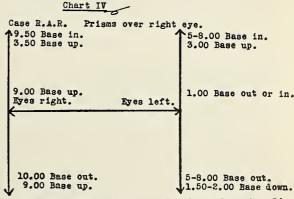
14/14. The pupils were equal, regular, and reacted to light and near. The fundus examination was normal. Eye movements were normal for all functions except that of convergence. The internal rectus



muscles functioned normally in conjugate lateral movements.

There was no diplopia for distance in any field. A horizontal crossed diplopia was noted when test object was brought within a meter distance of the eye. The diplopia increased as the object was brought nearer. There was a complete loss of adduction as measured with prisms. A one degree prism base out caused a diplopia for distant objects.

He was under observation for four months during which time no improvement was noted.



Case III—Bilateral Paralysis of the Superior Oblique Muscles: R.A.R.—white male—age twenty. Subject was injured in an automobile accident on January 22, 1944. He was unconscious for a period of about six days, during which time there was a

(Continued on Page 387)

MEDICAL SCHOOL

SOLITARY CALCIFIED CYST OF THE SPLEEN (Report of a Case)

H. W. Neidhardt, M.D.*

Kansas City, Kansas

Cysts of the spleen are uncommon, and of these the solitary, non-parasitic calcified types are quite rare, only seven cases having been reported in the literature. It is for this reason that a report of another case of this type seems desirable. The most recently reported case of this type was that of Dr. Paul O. Snoke¹.

CASE REPORT

W.R., a white male, aged fifty-six, was working on October 11, 1943, in an oil field ditch which caved in, throwing him against the opposite bank where he was struck about the region of the lower left chest, followed by pain on deep breathing.

Physical examination revealed considerable tenderness in the left upper quadrant and lower chest with limitation of respiratory movements.

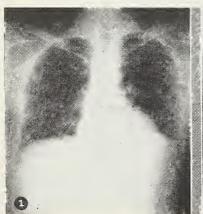
X-ray examination showed no fractures but a nearly circular, sharply outlined mass was seen in the left upper quadrant. The left side of the diaphragm was elevated, the apex of the heart was displaced considerably to the left, and the transverse colon and left kidney were displaced downward on the left side.

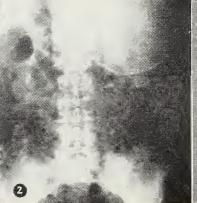
Two weeks later a laparotomy was performed and the mass was identified as a calcified cyst in the splenic region with a crack in its wall. Numerous fairly recent adhesions were present at the upper pole of the cyst, which was ruptured in its removal, and contained approximately 1000 cc. of thick chocolate colored fluid with a large number of minute shimmering crystals (probably cholesterol esters). Since the spleen was not found, it was assumed to be incorporated in the cyst. The patient made an uneventful recovery following the splenectomy.

Pathological report:—The specimen was an enlarged, ellipsoidal shaped, hollow cystic spleen weighing 630 grams and measuring eighteen by fifteen by eleven cm. Almost the entire organ was replaced by a cyst, the wall of which was largely calcified. The inner surface was fairly smooth and contained some blood clots. Small remnants of atrophied splenic tissue were recognized between the inner calcified wall of the cyst and the outer capsule of the spleen. The splenic substance varied between two and eight mm. in thickness. At one pole where the splenic tissue is most abundant there was a large, irregular laceration about seven to eight cm. in length. Histologically no lining membrane was recognized, and the splenic tissue showed a definite acute and chronic inflammatory reaction with diffuse fibrosis of the pulp. The capsule was considerably thickened. Pathological diagnosis: solitary calcifying cyst of spleen, acute and chronic splenitis and perisplenitis.

Three cases of solitary calcified splenic cyst are reported in the American literature and one in the British. Snoke's case was in a sixty-year-old white female suffering from gall bladder disease, the cyst being found on x-ray examination, the characteristic picture being that of an annular calcified shadow in the left upper quadrant. He mentions that this may be due to a calcified splenic cyst or an aneurysm of the splenic artery. The presence of a bruit in case of an aneurysm would serve to differentiate the two. Shawan's² case was in an eighteen-year-old white female. Culver, Becker, and Koenig's³, in a twentyfive-year-old female, is undoubtedly the largest specimen reported, measuring twenty-two by fifteen by ten cm. Scotson's4 case was in a forty-four-year-old

^{*} Department of Pathology, University of Kansas School of Medi-







The case of the calcification is unknown, but it is noted (Shawan²) that calcification in the spleen may manifest itself in: 1. scattered small deposits, 2. calcified vessels, 3. calcified cysts, 4. solid calcified tumors (extremely rare).

Likewise cystic disease of the spleen may manifest itself as: 1. large solitary cysts. These are considered by most writers as probably arising from small lymphangiectases, hemangiomata, or lymphangiomata with trauma as an inciting factor. (We found no direct evidence in our case to lend support to this view of origin of solitary cysts.) Torsion of the pedicle must also be considered as a possible cause. 2. Numerous small capsular or subcapsular cysts—the so-called infoliation cysts—which are said to develop from invaginated portions of peritoneal mesothelium, either developmental or inflammatory in nature. 3. Polycystic disease of the spleen. Here the entire pulp is uniformly riddled with many small cysts of varying sizes. The condition is generally considered developmental, but the possibility of an inflammatory process causing deep peritoneal invagination, as in the infoliation cysts, cannot be denied in all cases. 4. Large cyst with small daughter cysts. Echinococcus disease of the spleen would tend to assume this form, but smaller cysts have been found in connection with large, non-parasitic cysts³. In addition to the above processes, true neoplastic cysts may rarely occur such as the epidermoid cyst reported by Shawan⁵.

Since cystic disease is more common in the female than in the male, especially during reproductive life, it is possible that the cyclical changes in the organism, i.e. menstruation and pregnancy, which bring about periodic changes in the size of the spleen, predispose that organ to pathological processes^{6,7}.

An unusual case of cystic disease of the spleen is presented.

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- 4. Scotson, F. H., Brit. Med. Jour., 1;367, 1933.
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If the European war ends by December, 1944, it is predicted that a total of some 40,000,000 tons of human food and cattle feed will be necessary to keep the people of twenty nations at reasonable standards of nourishment until their domestic crops are available. The prediction is made by the Foods Research Institute, Stanford University.—California and Western Medicine.

EXPERT TESTIMONY COMMITTEE

With the approval of the Council, Dr. Trueheart has appointed a committee on expert testimony. This is the first time Kansas has had such a service.

An expert testimony committee offers to evaluate medical testimony upon request. Its services are extra-legal but its influence may be far greater than first thought suggests.

This committee represents Kansas medicine because it is appointed by the medical society. It is composed of doctors representing various specialties. It may, therefore, speak with authority about medicine. Its services are without charge.

We will invite the judges of Kansas, the Kansas Bar Association, and the state Compensation Commission to use this committee. There could be various uses, but one, to serve as an example, would be the request from a district judge for an unbiased scientific evaluation of medical testimony. The case has been heard and the judge wishes this advice before rendering judgment.

Actual benefits to be derived depend upon the legal profession, but there is no doubt that a psychological benefit will follow this gesture of sincere interest in improving the scientific content of medical testimony introduced in the courts of this state. Originating as it does from the profession itself, at a time when no outside agency has criticized existing conditions, it lends dignity to our offer.

We hope you approve of this plan and invite you to use the committee at any time you wish. Below are listed the doctors now serving:

THE EXPERT TESTIMONY COMMITTEE

- C. E. Joss, M.D., Topeka, Surgeon, Chairman
- L. G. Allen, M.D., Kansas City, Radiologist.
- C. R. Rombold, M.D., Wichita, Orthopedist
- J. W. Spearing, M.D., Columbus, Industrial Physician
- E. M. Sutton, M.D., Salina, Internist

1945 STATE MEETING

The annual session of the Kansas Medical Society will be held in Wichita, May 16 and 17, 1945.

As this year, the meeting will be streamlined in deference to the war. There will be a scientific program, the annual dinner, and exhibits both commercial and scientific. Except that the meeting lasts just two days, there will be no change from the annual sessions of years past.

BUY A BOND FOR VICTORY

^{*} AUTHOR'S NOTE—Grateful acknowledgement is made to Dr. Alfred O'Donnell of Ellsworth, Kansas, who has kindly furnished us with the material for this case.

President's Page

To the Members of the Kansas Medical Society:

The election is now over and we can settle down to our usual routine.

The Council had a meeting in St. Francis called for October 13. The most important business transacted was a vote by the Council to set up an expert testimony committee. This committee offers to review medical expert testimony given by doctors before any court or compensation board when asked to do so by a judge or compensation commissioner, or any interested party. This is a voluntary service on the part of the Medical Society. Its purpose is to keep medical testimony on a high plane.

Funds are coming in nicely for our post-graduate education fund which, I think, will serve a great need when our members begin to come back from the service. On another page will be a report of the committee in charge of this program. I would advise you to read it.

We wish to take this opportunity to congratulate Dr. John L. Lattimore on his election to the legislature.

Sincerely,

M. Trueheart. M. D.

President, the Kansas Medical Society

EDITORIALS

PHYSICIAN SHORTAGE

The Senate Subcommittee on Wartime Health and Education recently invited a group of persons to air their views on the high selective service rejection rate and, of course, federally controlled medicine.

The first topic was bandied about on pure logic. One-third of the men examined by selective service were found unfit, so it must follow that at least one-third and probably more of the rest of this nation exists in spite of physical handicaps. With that matter disposed of they veered toward the left with a neat little corollary to the effect that this deplorable situation would not exist if the misfit had gone to a doctor. It is only fair to assume that we do not like our physical handicaps so undoubtedly we would have had them corrected except for (1) the shortage of medical care, or (2) its prohibitive cost.

That's logic for you just like the classic we memorized in college: I like to do what is right and I always do what I like; therefore I always do what is right.

Present at the meeting also were members of the medical profession. They pointed to the fallacies in every step of the reasoning. They explained that this was a physical examination geared to eliminate those unfit for the rigors of war. Physical fitness in terms of flying a bomber is something very different from the physical fitness demanded for instance of the architect in peace time. The athletic program of our nation gives only vocal exercise to the bulk of the populace. We have not trained our youth for battle.

Moreover, only one out of six among these defects could be remedied under any conditions, and this group might have elected not to receive medical care. Perhaps ignorance as well as economics should be considered a factor.

A representative of the American Federation of Labor insisted that the solution lies in the principle of social insurance, that these principles should be extended to the health needs of all the people and hinted that the Wagner-Murray-Dingell bill offered a practical basis for such a program.

And so it goes. A wrong exists in the world and, fascinated by that fact, reformers sometimes inadvertently destroy a great deal of good in the unhappy attempt to rectify that wrong. This crusade takes on the attempt to create a Utopia of physical perfection. That means compulsory medical attention even to the extent of correcting minor defects. It can be pushed into the extreme of scientific breed-

ing on the grounds that the plan has worked wonders with horses.

In other words, they assume that when medical attention is free all remedial defects will be corrected. That presumes, of course, that the patient will then desert the quack who now charges many times the doctor's legitimate fee. Economics has not been a serious barrier to the cultists' existence today but maybe we are stretching the argument.

Not stretching it, however, is the fact that you must still have doctors before medical care, socialized or otherwise, can be administered effectively. If it is a shortage the government worries about they will either see that the study of medicine is attractive or certain selected students will be compelled to study medicine — or this shortage that they now deplore will become more acute.

MEDICAL LIBRARY

Unless you include lawyers, no group is as dependent upon current professional information as are doctors. Scientific publications are as vital to the physician as are the implements with which he works.

Obviously, no doctor can subscribe to all journals he may sometime find use for, so he selects those that most generally apply to the specialty in which he is interested. When other information is desired he consults a library.

The Kansas Medical Society has the nucleus of a medical library partly because of a fund created through the will of Mrs. Jane C. Stormont and partly because of book samples that are received by the Journal. At the present time these are placed for keeping with the State Historical Society.

Lack of space in their present quarters has placed these books where they are not easily reached. The library is so seldom used at present that there is no value in attempting to change the situation.

But a medical library could be of value. Books are constantly being added to this collection. If the doctors in the state could be given a yearly catalogue, these books would serve a greater purpose than they

JOURNAL CHANGES PAGE SIZE

In accordance with a plan to standardize page measurements of medical publications throughout the country, the Journal of the Kansas Medical Society has slightly increased the size of its pages, the change becoming effective with the October issue. By conforming to the measurements of a standard size page, the Journal will be able to accept the same size advertising plates used by other publications in the medical field.

do today. Accessions during the year would be reviewed by the Journal as they have in the past.

More than one hundred periodicals are received by the Kansas Medical Society in exchange for our Journal. After the editorial board scans them and the executive office glances through the material for items of interest concerning other state societies, these journals are donated to the medical library at Kansas University. There is certainly no objection to this practice except that such literature might serve our doctors better if all the material could be located at one place.

If you knew which books were available for loan, if a medical librarian with access to a cumulative index of medical literature could send you material on any subject you requested, if you could browse through a well-organized library, we believe you would use this resource.

A dream of this kind is expensive and perhaps it is not practical. However, the legal profession has a splendid law library and certainly their need is not greater than our own. Their periodicals are bound. Their books are catalogued and we are told that Kansas lawyers have extensive use of this service.

Ours is still a dream, but a dream that is far more than that to Dr. F. E. Vest, chairman of the Stormont Library Committee. Certain private inquiries he has made reveal that such a project is not at all impossible. He is speaking in terms of this library as though it existed today and would gladly receive comments or suggestions from you.

CIVILIAN AIR TRAVEL

Airlines are again asking for business. At least two factors contribute to change this situation. First, military aircraft production has reached a pace where ships borrowed by the government early in the war are now gradually being returned to private companies. Second, essential air travel of military personnel has either been reduced or is being more nearly cared for in government owned planes.

At least, we are told that ships are often flown with less than capacity loads. The public, warned to expect last minute seat cancellations, has stopped inquiring about air travel. The emergency in the industry has passed, and today airline officials are again inviting civilian passengers to go by air. Representatives of several companies have stopped at your executive office to ask that this information be forwarded to the doctors of Kansas.

Priorities are still in effect, however. Your reservation on an airplane is still subject to cancellation

exactly as before. The only difference is that it occurs less frequently today and the delay is usually shorter. If you find yourself deplaned, you will probably be given a seat on the next flight. Supporting this statement is the report that one airline flew 650 vacant seats out of one midwest port in the course of last month.

AMERICAN COLLEGE OF SURGEONS EXPANDS GRADUATE TRAINING PROGRAM

In expanding its program of graduate training in surgery to assure adequate opportunities for advanced training in surgery, particularly for recent medical graduates when they return from service with the armed forces, the American College of Surgeons has enlarged its headquarters staff in Chicago and announces the following new appointments effective immediately.

Major General Charles R. Reynolds (M. C., Retired), former surgeon general of the U. S. Army, has been appointed consultant in graduate training in surgery.

Dr. George H. Miller, formerly dean of the faculty of medicine and chairman and professor of the department, American University of Beirut, Lebanon, Syria, has been appointed director of educational activities.

The department of graduate training in surgery is under the general direction of Dr. Malcolm T. McEachern, chairman of the administrative board, working with that board, and responsible to the committee on graduate training in surgery, of which Dr. Dallas B. Phemister of Chicago is chairman, and to the board of regents. In addition to General Reynolds and Dr. Miller, the staff of the department consists of Dr. Paul S. Ferguson, director of surveys, and three assistants who conduct the surveys; and the field representatives conducting the regular hospital standardization surveys under the direction of Dr. E. W. Williamson, assistant director of the college, who assist as required in the graduate training program. The latter is a development of the basic work of the college in stimulating the improvement of hospital service.

Surveys of hospitals for graduate training in surgery have been conducted since 1937 by the college. When the war ends in Europe, in order to satisfy the demands of men whose training in surgery was interrupted by war service, together with those of current medical graduates, sufficient opportunities should be ready to offer approved training to men who wish to become surgeons, Dr. MacEachern declares, adding that a competent surgeon according to present day ideas requires a preparation of three or more years of systematic, supervised graduate training in general surgery or a surgical specialty, following a general internship and graduation from an acceptable medical school.

SURGICAL ASSOCIATION TO MEET

The Western Surgical Association will meet at the Hotel Drake, Chicago, December 1 and 2, 1944. This will be the first meeting of the group since 1941 as the 1942 and 1943 meetings were not held because of the war.

* BUY AN EXTRA BOND

TWA turned over its fleet of Stratoliners, formerly in its domestic service, to the Army shortly after Pearl Harbor. They were in global service for the Air Transport Command until a few months ago when the Army returned them to TWA, and have been undergoing modification at the Boeing plant to reoutfit them as passenger transports. This will include the installation of more powerful engines.

UNCOMMON PARALYSIS OF EXTRA-OCULAR MUSCLES

(Continued from Page 381)

paralysis of the right side of his body. X-Ray revealed a fracture of the left parietal bone and the left clavicle. Following the paralysis, numbness and tingling persisted on the right side. He has difficulty in enunciating certain words.

Upon being admitted to this hospital on March 23, 1944, a spinal puncture revealed clear fluid under pressure of 150 mm. of water.

Examination of his eyes on May 17, 1944, revealed the following: vision—O.D. 20/20, O.S. 20/20. The right pupil was larger than the left, and both pupils reacted to light and near. Fundus examination was negative. There was diplopia in the lower field, which was charted on a screen, 100 cms. square, from a distance of seventy-five cms. The red glass was over the right eye. There was found a paralysis of each superior oblique muscle. (See chart No. I) The cover test confirms that finding. (See chart No. II)

Similar diplopia fields were charted on May 23, 1944, using a horizontal bar. The results are given in chart No. III, the horizontal dots representing the image of the right eye. The image of the right eye is lower on looking down to the left, and the image of the left eye is lower on looking down to the right. The torsion is not as conclusive because of improvement in his condition by that time, as indicated in chart IV.

A paralysis of this type indicates the presence of two lesions.

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

A statement of the policy and program of operation of the National Foundation For Infantile Paralysis was prepared for the Journal of the Kansas Medical Society by Mr. Earl Bevan of Emporia, state representative of the foundation. Because of the interest in this program in Kansas, the article is presented in its entirety.

"The National Foundation For Infantile Paralysis was organized in 1938 to direct, stimulate and unify research in the prevention of the disease and methods of treating the after-effects, as well as to render direct medical aid to

victims of infantile paralysis regardless of age, race, creed or color.

"The research programs are sponsored by the national foundation through grants following recommendations of its medical advisory committees. These committees are composed of eminent medical authorities meeting twice a year to plan, discuss and approve programs of study financed by the national foundation to be undertaken at leading universities, laboratories and hospitals. In the past six years, 298 such projects have been carried out at a cost of more than six million dollars.

"The second phase of the national foundation's plan, medical aid to victims of infantile paralysis, is financed largely by the local chapters of the foundation. Today there exists a chapter in nearly all of the 3,070 counties of the United States. Its task is to help the infantile paralysis sufferer. Such aid may take many forms, as paying all or part of hospitalization costs, hiring nurses or physical therapists, paying for orthopedic surgery, purchasing orthopedic braces and appliances, and, in short, doing anything that will help the victim to return to normal life. Rendering such aid entails many medical problems and the cooperation of many medical and welfare agencies. In order that the chapter spend its money wisely, and to facilitate cooperation among existing agencies, medical advice and supervision is necessary. Each chapter is required to have a medical advisory committee of its own to help it work out the medical problems peculiar to its own locality. This committee may be only one medical man if the community be that small, or it may consist of as many of the area's physicians and health officers as wish to serve. Whatever its number may be, such a medical advisory committee is essential to the efficient functioning of the chapters of The National Foundation For Infantile Paralysis.

"Kansas chapters endeavor to secure on their medical advisory committee the health officers for their counties, and all, if possible, of the physicians in the county. With this medical advice available, the procedures involved in giving proper care and treatment to infantile paralysis victims are correctly outlined and effectively followed."

ALLERGY FORUM IN JANUARY

The seventh annual forum on allergy will be held at the Hotel William Penn, Pittsburgh, Pa., on Saturday and Sunday January 20 and 21, 1945. An invitation to attend is extended to all physicians and scientists interested in this field.

The forum was organized in 1938, to provide a place in which to review the progress of clinical allergy and to offer post-graduate instruction in allergy to physicians working in other fields. The program this year calls for twelve study groups, any two of which are open to each physician, and will include lectures by outstanding physicians, pictures, demonstrations, symposia and panel discussions.

The American Association of Allergists for Mycological Investigation will hold its annual meeting on Friday evening preceding the forum.

Further information may be secured by writing Jonathan Forman, M. D., 956 Bryden Road, Columbus 5, Ohio.

The art of medicine consists in three things: the disease, the patient and the physician. The patient must combat the disease along with the physician.—Hippocrates, "Apphorisms."

EXECUTIVE OFFICE

This column is designed to inform you of material reaching your executive office. Each month we plan to review subjects that seem to us important enough to call to your attention. Views herein expressed will generally be personal and not necessarily the result of official action, but they will, naturally, reflect the activities your Society is either contemplating or engaged in.

Again this month we wish to comment on your plan to provide a post graduate education fund. For the purpose of keeping the record straight, the correct title seems to be The Kansas Medical Education Fund. You are familiar with the plan to raise \$100,000 through voluntary subscriptions. It will be used to provide post graduate education for Kansas doctors who are now in service, to obtain for the University of Kansas a permanent Graduate School of Medicine and to offer Kansas physicians graduate education.

This is perhaps one of the most important projects ever attempted by the Society, and as such needs careful consideration. It represents almost \$100 from each member, which amount should not be given carelessly even if motivated by patriotic enthusiasm. No one is expected to give unless he approves of the plan and unless he is assured that the fund will be utilized to the best interests of Kansas medicine. We have tried to inform you of the details through the Journal so that suggestions you might have would be forwarded.

Many comments have been received. Below is part of a letter to Dr. Trueheart from a Kansas doctor in the Army. It expresses the feeling of at least one of the men for whom we are raising this money.

"I received the Journal telling of your program to provide some post graduate work after this is over. Brother, we certainly will need it. Anyone who has been in the Army realizes what happens to one's skills after several years, especially if he is in a field unit. I believe that there will be a big demand for short courses, say six weeks to three months, in obstetrics, general medicine, general surgery, and urology. Many changes have taken place in these fields in the few years we have been out of active practice. There will also be a moderate demand for orthopedic, psychiatric, and pediatric courses.

"I assure you that we who are away appreciate your efforts in our behalf and will do anything possible to help you."

Local interest is also high. Checks ranging up to one thousand dollars are arriving regularly. Unsolicited donations from non-medical persons are often included. It seems now that the goal will be reached and that the next problem concerns details of setting up the program.

Foremost among the questions you raise is whether the veteran may be permitted to use this money for education in other schools. Dr. Harold H. Jones, chairman of the Post Graduate Education Committee, enthusiastically agrees that the medical officer returning from service should be permitted to select his school as well as the course he wishes to attend. The committee will recommend to the Council that no coercion be exercised to control the veteran's choice of school. You give this money as a token of gratitude to the man in service, and you want it to serve his needs. Any course short of this will be contrary to the original

directive by the House of Delegates authorizing the program.

Graduate courses will be offered at the University of Kansas School of Medicine for all returning officers who wish to study there. Plans are already under way for enlarging facilities and adding whatever may be necessary for such work. The University of Kansas will cooperate to the fullest extent.

Once this school is established, it shall be permanent. Subjects shall be varied and will be selected by a central committee to comprise those requests most frequently received. At first, men returning from service will be given preference, but after those needs are fulfilled, enrollment from civilian members of the Kansas Medical Society will be accepted.

Dr. Jones proposes that the short post graduate courses shall continue to be given throughout the state as they are at present. Well known speakers will be obtained on a variety of subjects. This is designed to serve the doctor who does not find it expedient to spend several weeks away from his practice.

You should also be interested in the mechanics of how this fund shall be controlled. Dr. Jones has already proposed an answer to the effect that this will be set up apart from other Society money, that several doctors' signatures be required for each check drawn on the account, and that the Council approve the various steps of the program before they become effective.

We have tried to think this through and would like to offer the following suggestions as a basis:

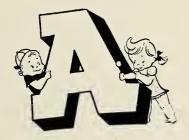
- 1. The Council meets too infrequently to be effective in directing minor steps in the program. Perhaps once or twice each year the Council might approve a contemplated program and budget. At the state meeting a report shall be submitted to the House of Delegates.
- Details should be the responsibility of the chairman of the Committee on Post Graduate Study. He has studied this and is better acquainted with details than anyone else.
- When applications begin to arrive, they should probably be reviewed by this committee and passed on, according to standards that shall be set by the Council.
- 4. Checks drawn on this account should be valid only when several authorized signatures appear on them. By way of example, they might require the signatures of the president, the treasurer and the chairman of the Committee on Post Graduate Study. Books, of course, will be kept as they are for all other finances in which the Society is interested.

At the present time these are merely suggestions. Most of them originated with Dr. Jones who has given a great deal of time and work to this program. He is determined that the program will succeed and is optimistic because you have become interested in its success.

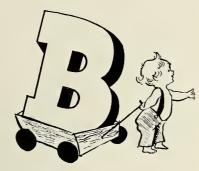
He advises that this is now and shall remain a project of the Kansas Medical Society. The funds will continue to be under your control, and the graduate school shall be thought of as a war memorial. For those reasons Dr. Jones welcomes any suggestion you have for making this program more effective. He appreciates your cooperation and believes you will be proud of this, one of the great projects in the history of the Kansas Medical Society.

A physician may possess the science of Harvey . . . and yet there may be lacking in him those finer qualities of heart and head which count for so much in life.—Sir William Osler.

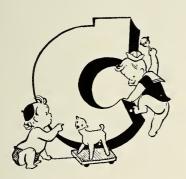
The ABC of Vitamin D Therapy



Prevention of rickets is part of the daily routine in the care of infants and young children. Hence there is a big advantage in simplifying the administration of vitamin D.



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THIOURACIL IN THE TREATMENT OF HYPERTHYROIDISM

(Continued from Page 379)

June 20 her basal metabolic rate was plus 34, she began to show more improvement, and the average daily pulse rate was about 100. Her weight was then 108. We felt that the effects of thiouracil were definitely noticeable. On June 26 her basal metabolic rate was still about 34, and the average daily pulse was running around 95. Her weight had begun to take a definite rise and was now up to 112 pounds. About June 15, passive edema of the ankle was noticed. This lasted only about one day, and it was felt that it was probably due to the large dosage of the drug which was being administered. Transient edema was reported by Astwood. On July 3 the BMR was plus 11 and the pulse was 92. The weight was up to 115.

This patient is still being followed in the hospital, and it is felt that she is a fairly resistant case. It must be remember that her case was complicated by a chronic nephritic condition and a tuberculous condition of questionable activity. These two factors may have something to do with the resistance. However, definite improvement has been noticed, as shown by the above description.

DISCUSSION

In evaluating clinically the significance of this new drug, we must take into consideration the clinical benefits that have been derived in the past from the usage of Lugol's solution, bedrest, and phenobarbital. In these cases treated in this hospital we have noticed, however, several differences between the thiouracil and the iodine treatment:

- (1) The effects of the thiouracil appear to be manifest even though the patient is ambulatory and not treated as a bed patient. This is illustrated in cases I, II, and V.
- (2) The patient does not seem to become tolerant of the drug as he does with iodine. In fact, in several cases here that we have followed long enough, the dosage of thiouracil has actually been cut down rather than increased, as it has to be with the Lugol's solution. This is illustrated in the cases above, namely I, II, and V again.
- (3) Thiouracil seems to produce results in patients who are resistant to iodine as well as in those who are not.
- (4) We have noticed a definite but variable latent period in the effects of the thiouracil. Almost uniformly in our cases here there has been a definite improvement in the clinical symptoms before there have been any of the objective findings, such as the basal metabolism and the pulse and blood pressure.

With the facts in mind, we believe that thiouracil

has a definite place clinically in the treatment of hyperthyroidism. In fact, we believe that in many cases it has definite advantage over the use of Lugol's solution and in some cases it is apparently satisfactory in the treatment of even those with severe toxicity in lieu of operation. The indications are that the drug may entirely correct the physiological and functional manifestations of the disease. Surgery would then be limited to the removal of the enlarged gland, or in other words, the correction of the mechanical factor. Cases I, II, and III illustrate very nicely the use of x-ray in correcting the mechanical factor. In all these cases a very good result was obtained, and at the same time did not expose the patient to the danger of surgical operation. However, any final conclusion regarding the prolonged clinical usage of this drug will have to await further follow-up on these patients. Only a follow-up over a long period of time will give us an idea of the permanency that can be expected from its use. In every case here in which the drug has been tried, we have noticed a definite improvement providing the drug was continued long enough.

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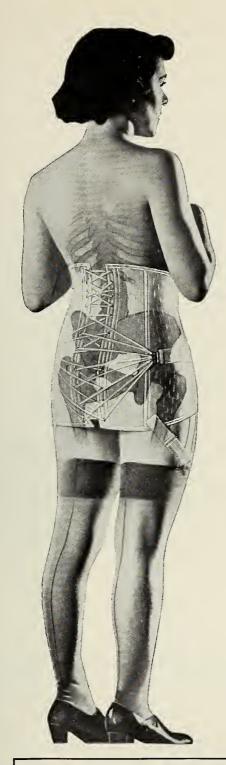
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ADDENDA — Since this paper was submitted for publication, case III has gained 25 pounds, the heart has stopped fibrillating and the rate is 72; case VI has gained 10 pounds more and her BMR became 0 in addition to complete amelioration of symptoms.

CANCER AWARD TO DR. SPENCER

The Clement Cleveland award for outstanding service during 1944 in the effort to control cancer by education was presented to Dr. R. R. Spencer, chief of the National Cancer Institute, Bethesda, Maryland, on October 31, by Dr. Frank E. Adair, president of the American Cancer Society, in New York City.

Dr. Spencer advocates organization of all cancer activities on a national scale, and the medal was awarded him for his educational work in writing articles for the layman.



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MEN IN SERVICE

EDITOR'S NOTE—The editorial board and staff wish to send the Journal regularly each month to all members of the Kansas Medical Society now in the armed service, either in this country or abroad. The Journal receives many notices of change of address, but that information is often, of necessity, delayed, particularly data about APO and FPO addresses. We ask, therefore, that all Journal readers notify the Journal office immediately of each change of address.

Postal regulations will not permit listing of addresses of those serving overseas, but the Journal office will be happy to supply complete addresses whenever possible, by request.

Capt. Clovis W. Bowen, flight surgeon with a Combat Crew Training School (H), advises that his address now is 213th Combat Crew Dispensary, Office of Supervisor, Mountain Home Army Air Field, Mountain Home, Idaho. He was graduated from the School of Aviation Medicine as an A.M.E. in July, 1943, was promoted to captain in November, 1943, and became a flight surgeon in September, 1944.

Capt. Ward M. Cole, MC, writes that he is still stationed in the Aleutians. "Winter is not far away," he said, "as we have had several snowstorms and the snow is staying on above the two thousand foot level now. Are living quite comfortably in Quonset huts. Sickness rate here is very low as we have but few upper respiratory infections and practically no contagions.'

Major John A. Grove, Newton, A. P. O. New York, writes the following in a recent letter:

"One of our hospital units had a visit from General Eisenhower some time ago. He made his way about with only a minimum of heel clicking and visited every enlisted man. Seemed especially to be looking for Kansas boys. Really the man has a way about him. The whole place fairly beamed and you could see the lift for days after he left. I think perhaps the confidence he generates about him comes not from military agressiveness but some touch of Lincoln-like qualities. Believe me, we're all sold on that Kansas product."

Col. William C. Menninger, Topeka, now serving as chief consultant in neuropsychiatry, office of the surgeon

The Neurological Hospital, 2625 The Paseo, Kansas City, Missouri. Operated by the Robinson Clinic, for the care and treatment of nervous and mental patients and associated conditions.

general, received the first Lasker award of \$1,000 for distinguished service in the field of mental hygiene at the annual meeting of the National Committee for Mental Hygiene in New York City recently.

CHANGES OF ADDRESS

Capt. R. E. Baldridge, Kingman, to an APO out of New

Capt. P. E. Beauchamp from Lubbock, Texas, to Camp Fannin, Texas.

Lt. A. E. Cooper from a New York FPO address to the Naval Air Station, Hutchinson, Kansas.

Major S. T. Coughlin from Randolph Field, Texas, to the Enid, Oklahoma, Army Air Field.

Lt. H. H. Crank from Farragut, Idaho, to San Bruno, California.

Capt. Paul E. Davis from Fort Snelling, Minnesota, to Schick General Hospital, Clinton, Iowa.

Cappt. E. W. Enders to the 15th Field Hospital, APO, New York City.

Capt. A. W. Evans from Norton, Kansas, to Fort Leonard Wood, Missouri.

Major Kenneth R. Grigbsy from an APO, New Orleans, to an APO, New York.

Capt. Raymond Hughes, Manhattan, to an APO, New York.

Lt. R. H. Kiene from a San Francisco FPO to a naval training school at Plattsburg, N. Y.

Capt. H. L. Kirkpatrick to an Army Air Base, Ephrata, Washington.

Major L. H. Leger from Fort Sam Houston, Texas, to Camp Barclay, Texas.

Capt. Guy B. McIlvain from a San Francisco APO to a Seattle, Washington, APO.

Lt. N. C. Nash from Billings General Hospital, Indianapolis, to Fitzsimmons General Hospital, Denver.

Capt. E. J. Schulte from Camp Barclay, Texas, to Fort George Meade, Maryland.

Major R. E. Speirs from Fort Leonard Wood, Missouri, to an APO, New York. Lt. Harold F. Spencer from a San Francisco FPO to the

Naval Hospital, Oakland, California. Lt. W. F. Stone from Mare Island, California, to the

Naval Air Training Center, Pensacola. Lt. Samuel T. Thierstein from Chicago to Carlisle, Penn-

sylvania. Capt. C. C. Underwood from the Altus, Oklahoma,

Army Air Field to an APO, New York. Lt. Walton C. Woods, Manhattan, to an APO, New York.

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ, Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

BELGIANS EXPRESS GRATITUDE

The deep appreciation of the Belgian people for the liberation of their country is expressed in the following communication from the regular correspondent in Belgium for the Journal of the American Medical Association, the first word the Journal has received from him since the Germans first occupied the country.

"The people of Belgium deeply appreciate the liberation of our country by the Allies. They have shown their patriotic enthusiasm for the cause of liberation and their admiration for your army. We, the Belgian physicians, wish to express also our deep gratitude to your country and our admiration for your army. We are now able to see for ourselves on our reconquered soil the amazing organization of war surgery that has been built up by the Allies at the front. Because of our experience with the hospitals during the war of 1914-1918 we can appreciate the progress achieved in the care of the wounded, and we propose to learn from contact with your medical officers the advances in war surgery that have given such good results in this war.

"I wish to write a few words regarding our experiences during the occupation: The practice of all Belgian physicians was regulated by a dictatorial order which had many arbitrary rules (for authorization to practice, location of physicians and similar matters). Fortunately these regulations were received generally with inertia, and 90 per cent of physicians continued practicing without openly

protesting against the regulations, suffering vexation, to be sure, but practically ignoring their existence.

"As for the Belgian medical press, two journals continued to be published, one in Flemish and one in French. Some of the material of medical journals which were suppressed by the invaders was provisionally published by the International Office of Medico-Military publications in the Archives Medicales Belges from May 10, 1940. We never could obtain any medical literature except from Germany. All papers were suppressed by the invaders. The literature that we received consisted of medical items from Swiss journals sent to us in envelopes as if they were letters.

"The nightmare is over now. The medical profession and the rest of the country are ready to resume their normal place in the world."

RECOGNIZES HEALTH PROBLEM

Recognizing the complexity of the problem of American health, the Railroad Journal devoted its entire August issue to that topic, featuring articles on health protection and health and hospitalization insurance. Many acknowledged leaders in medical and hospital fields were contributors.

The importance of this step by the Railroad Journal is of interest to the medical profession since it is evidence that American industry is realizing its responsibility to its people and is recognizing public health problems in their true light.

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The American Urological Association offers an annual award, "not to exceed \$500," for an essay or essays on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the committee on scientific research deems none of the offerings worthy, no award will be made.

Competitors are limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. Essays must be in the hands of the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1945, and additional information may be secured from him.

PHYSICIANS MEET AT NAVAL BASE

A meeting for medical men of the Kansas City and Olathe areas was held at the Olathe Naval Air Base, October 11. Thomas G. Orr, M.D., professor of surgery at the Kansas university school of medicine, spoke on "Factors Influencing Mortality in Cholecystectomy," and Lt. Francis Kenny of the air station dispensary read a paper, "Military Aspects of Teratomata." A sound movie, "Nutrition and Vitamin Deficiencies," was shown under the auspices of the National Research council.

No physician, in so far as he is a physician, considers his own good in what he prescribes; for the true physician is also a ruler having the human body as a subject and is not a mere money-maker.—Plato.

DEATH NOTICES

Dr. Otto Kiene, age 65, of Concordia, died at a Kansas City hospital November 6, after having been ill with a heart ailment for several weeks. Dr. Kiene, a fellow in the American Medical Association, was graduated from the Kansas Medical College, Topeka, in 1904, and was associated with Dr. W. F. Bowen and the late Dr. J. C. McClintock in Topeka. Thirty years ago he moved to Concordia and established a practice over north central and northwestern Kansas, specializing in surgery. He was a member of the Cloud County Medical Society. A son, Dr. Richard Kiene, is now serving in the medical corps of the United States Naval Reserve.

Dr. Ivan B. Parker, 73, who had been practicing in Graham county for 46 years, died at his home in Hill City on October 4. He was graduated from the University Medical college of Kansas City, Missouri, in 1894, and started practice in Morland in 1898.

Dr. Nathan George Bennett, 71, died at his home in Haviland on October 8. At 19 years of age he came to Kansas from Ohio and, after teaching for five years in county schools, began the study of medicine at Kansas university. He was graduated from Barnes Medical college in St. Louis in 1902. He started practice in Haviland that year and continued there until his death.

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PUNISHMENT FOR VENEREAL DISEASE IN ARMED FORCES ABOLISHED

The signature of the President has now enacted into law a measure which repeals the act which provides for the forfeiture of pay of persons in the military and naval service of the United States who are absent from duty on account of the direct effects of veneral disease due to misconduct. The new law, S. 1250, also amends Veteran's Regulation No. 10, defining line of duty and misconduct for pension and compensation purposes.

The law abolishing punishment for the acquisition of veneral disease, which is now "in line of duty" and is not "due to wilful misconduct," is applicable only if the infected person complies with Army or Navy regulations requiring him to report and receive appropriate treatment and if, at the time of infection, he was neither avoiding duty by desertion or absence without leave, nor confined under sentence of court martial or civil court. Failure to report a veneral infection remains punishable by court martial or other disciplinary action at the discretion of the commanding officer. In addition, the new law provides that, with the exceptions noted, veterans who have acquired veneral disease in line of duty are eligible for pension and compensation if disability results.

The law is not retroactive. A claim heretofore disallowed by reason of misconduct or line of duty requirement may not be revived, but benefits may be payable on the basis of a new claim filed hereafter in such form as may be prescribed by the Administrator of Veterans' Affairs.

The Surgeon General of the Army, the Subcommittee on Veneral Disease, the National Research Council, and other authorities in social hygiene and preventive medicine have long advocated abolishing punishment for veneral disease. It has been felt that fear of punishment does not prevent exposure to veneral disease and that punitive measures promote concealment, self treatment and treatment by non-military personnel. Concealment, in turn, results in continued spread of disease. Punishment discriminates since military personnel may be penalized not for the fact of infection but for the failure to respond to treatment. Under the new law the soldier or sailor infected with a veneral disease is now on the same status as one with any other acute infectious disease.

DIES A MARTYR TO SCIENCE

Latest martyr to science, whose name might well appear on the rolls of dead heroes of this war, was Dr. Richard G. Henderson, senior assistant surgeon, U. S. Public Health



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Service, who died at the naval hospital recently.

Tsutsugamushi disease, also called scrub typhus, killed Dr. Henderson as he was working on the development of a vaccine to protect American fighting forces from this plague of the Pacific.

How he contracted the disease is a mystery. Ordinarily it is spread by mites, but there are no mites at the National Institute of Health, where Dr. Henderson was working. Nor was there any laboratory accident to account for his getting the infection. The 32-year-old scientist started working on the disease three months ago, at the request of the military authorities.

Scrub typhus is caused by germs belonging to the rickettsia family, to which also belong the germs of typhus fever and Rocky Mountain spotted fever. A rash, enlarged glands and lung inflammation like pneumonia are the chief symptoms. Dr. Henderson died of the pneumonia of the disease. No specific treatment or "cure" is known for scrub typhus. It is fatal in about seven per cent of the cases .-- Science Service.

MODIFICATION IN PROCUREMENT

The Army is discontinuing commissioning physicians from civilian life who were declared available prior to October 20, 1944, reports Dr. F. L. Loveland, chairman of the Kansas Procurement and Assignment service. A number of applications now in process will be made available to the Veterans Administration, however.

Regulations state that medical students, interns and residents who are commissioned in the medical corps, the medical administrative corps, or are students under the Army specialized training program, may be expected to serve in the Army as soon as they become qualified for

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assignment to active duty. The Army will continue to request occasional availabilities for specific position vacancies in cases of physicians who have been desirous of service and who are now, or in the future will be, available for the first time because of replacements or returning veterans.

The Navy and the U. S. public health service continue to have urgent need for three thousand and three hundred physicians, respectively, and those physicians who can be declared available should be referred to the attention of those branches of the armed forces.

CLINICS AT GREAT BEND

Physicians and surgeons from Great Bend, Larned, Ellinwood, Hoisington and other communities in that locality have been invited to attend a series of clinics to be held at the station hospital, Great Bend Army Air Field, by Major Curtis A. Meyer, base surgeon. The meetings will be held on the first and second Thursdays of each month.

The clinics include making of ward rounds and analyzing and discussing special medical and surgical cases.

NPC SPONSORS MEETING

A meeting of professional, insurance and industrial leaders will be held in New York City on Monday, November 27, under the auspices of the National Physicians' Committee for the Extension of Medical Service. The meeting was planned to examine and evaluate industry group insurance programs in terms of management's approval and employee benefit and satisfaction, and the topics to be discussed include extension of medical care and employer-employee cooperation.



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NEWS NOTES

Three Wichita physicians, Dr. C. Alexander Hellwig, Major Ralph L. Drake of the Army, and Lt. Comdr. James S. Hibbard of the Navy, were co-authors of an article, "The Adrenal Medulla in Various Diseases," which appears in the June, 1944, issue of Archives of Pathology.

Dr. R. H. Felix, Downs, has been appointed director of the mental hygiene division of the U. S. Public Health Service.

An article by Col. William C. Menninger, "Psychiatric Selection of Men for the Armed Forces," was published in the September 23, 1944, issue of the Journal of the American Medical Association.

Dr. Daniel Wilson, formerly of Kansas City, is now practicing in Jetmore. He is the only doctor in Hodgeman county at this time and has been appointed county health officer.

Dr. Herlan Loyd, general practitioner, has moved from Little River to Arkansas City.

Dr. V. M. Winkle, who has been in public health work in Scotts Bluff, Nebraska, has been named assistant to Dr. D. D. Carr, Topeka.

Dr. Marion Trueheart, president of the Kansas Medical Society, gave an illustrated lecture on cancer and its control to the Rozel Farm Bureau unit on October 20.

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Frank A. Paschal, state elementary school supervisor, has been appointed state director of health education for the Kansas Tuberculosis and Health association, according to an announcement made recently by Charles H. Lerrigo, director of the association.

Dr. V. F. Amend has moved from Ellinwood to Great Bend, and is now practicing there.

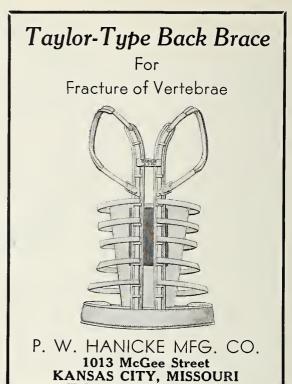
Dr. Stanton A. McCool, formerly of Seneca, is now practicing in Elma, Washington, and has been appointed health officer there.

Dr. E. J. Beckner, Butler county health officer, addressed the regional staff meeting of the Public Nursing department at the office of the Sedgwick County Health Department, Wichita, last month. His topic was "Medical Supervision and Prevention of Complications During the Pre-Natal Period." He also spoke recently to the E.M.B. club of Towanda on the use of penicillin and sulfa drugs.

Dr. W. S. Tucker, one of the founders of Elkhart, has leased the Tucker hospital there and is retiring from practice. A physician for almost 40 years, he also served in the state legislature and was a municipal official for a number of years. He was named Elkhart's "most useful citizen" by overwhelming vote several years ago.

Dr. C. S. Hershmer, Esbon, was elected president of the National Proctological association at its annual meeting in Chicago last month. This is the first time in the history of the association that a president has been chosen from west of the Mississippi river.

Dr. W. H. Clarkson has been named president of the



Parkview hospital, Manhattan, by the hospital board of directors.

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KANSAS MEDICAL ASSISTANTS' SOCIETY

PLAN MEMBERSHIP DRIVE

With a goal of 400 paid memberships by May, the Kansas Medical Assistants' Society is starting a campaign to enlist the support of all who are eligible for membership. Dues, fifty cents a year, are payable in January. Each member is urged to secure one new member.

The constitution and by-laws of the society dictate that only members in good standing 30 days prior to the May meeting are eligible to vote in the state election. Although this provision has not been enforced in the past, it is planned to adhere to the rule this year. Organized societies should send in their dues as a group, and individual memberships should be sent to Charlotte Parish, 706 Orpheum Building, Wichita, Kansas.

Mrs. Florence Linton, Topeka, is chairman of the membership drive.

Margaret McKillip, Wichita, has been named secretary of the Kansas Medical Assistants' Society to fill the unexpired term of Dolly Harrington, who resigned to accept a position in Oklahoma City, according to announcement made recently by Zura Crockett, Wichita, president. Miss McKillip has been secretary to Dr. Charles Rombold for the past two years and has taken an active part in the work of the Sedgwick county assistants' society.

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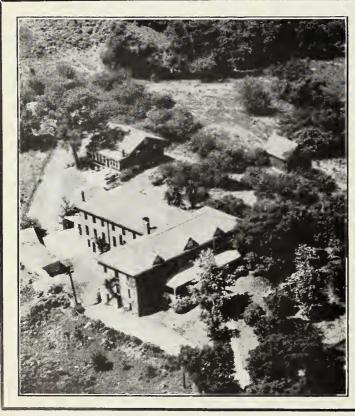
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much has been learned through the unfortunate occurrence of the Cocoanut Grove fire at Boston. The numerous reports in the medical press emphasize the need for large amounts of dietary protein of adequate biologic value, given as early as possible.* Meat is one of man's main sources of protein that can be eaten with relish several times daily in goodly quantities; its proteins are of highest quality, and it contributes to the satisfaction of the greatly increased vitamin requirements as well.

[&]quot;... at least from 200 to 300 grams of protein is needed for replacement alone. One must give the patient as much food as he can take... give him a good protein, one that contains all of the essential amino acids." (Elman, R.: Physiologic Problems of Burns, J. Missouri M. A. 41:1 [Jan.] 1944.)



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^{*&}quot;All the patients with ten per cent of surface area, or more, involved in third-degree burns became serious nutritional problems... All patients were started on high protein, high vitamin diets... This diet contained 140 Gm. of protein." (Clowes, G. H. A., Jr.; Lund, C. C., and Levenson, S. M.: The Surface Treatment of Burns, Ann. Surg. 118:761 [Nov.] 1943.)

Blenda Blankenship, Topeka, will serve as corresponding secretary of the state organization, completing the term of Mateel Todd, formerly of Topeka, who has accepted a position in California. Miss Blankenship, a member of the Shawnee county group, is secretary and operative record librarian at Stormont hospital.

The October meeting of the Shawnee County Medical Assistants' Society was held October 10 at Garfield Park, Topeka, with 38 members attending. The hostesses, Grace McMillen, Gladys Stock, Teresa Nelson and Nadine Kneudsen, served a picnic dinner, after which there was a business session and bingo party. Special recognition was given Grace Hamilton, the first member of the Shawnee county group to enter the armed service. Now Lt. Hamilton, she is undergoing basic training at Camp Carson, Colorado.

The medical assistants of Wyandotte county held their October meeting at the Kansas City, Kansas, chamber of commerce building. Dr. H. H. Hesser of Kansas City was guest speaker, using for his topic, "The History of Surgery." During the business session, Grace M. Skwarlo was named publicity chairman for the society.

Members of the Sedgwick county assistants' society met at the Allis hotel, Wichita, on October 18. The forty members present enjoyed hearing Miss Jessica Smith, teacher at Wichita North high school, report on the world conference of teachers held in Washington, D. C., recently.

The regular monthly dinner meeting of the Reno county assistants group was held at the Wiley tea room at Hutchinson November 14. Zelma Leeburg reviewed the book Burma Surgeon. Plans for a Christmas meeting were discussed.

CLASSIFIED ADVERTISEMENTS

FOR SALE—Well equipped office and practice of deceased physician. Large practice—good county seat town (pop. 1,500) and large territory. No doctor in town. Write the Journal C-0-20.

FOR SALE-Office equipment of retiring physician engaged in general practice including complete line of instruments, instrument tables (2), sterilizer, anesthesia table, sterile cabinets, irregator stand, centrifuge. Everything in the best of condition. Write C-O-6—The Journal.

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FOR SALE—Large assortment general surgical and bone instruments. Cold quartz and carbon lamps. Bone engine, splints, etc., all about as good as new and prices about 15 per cent of cash. Tell me your needs and let me quote price. C-O-12—Journal office.

FOR SALE—Two used examination tables, and three wood, leather-padded, treatment benches. No reasonable offer refused, write: C-O-5.

FOR SALE—Tonsil and adenoid outfit in good condition at a big reduction. Write—Journal C-O-10.

FOR SALE OR LEASE—Kansas physician's and surgeon's practice on account of death; established 40 years; good steady income; equipment included; excellent opportunity. Write Journal of the Kansas Medical Society—C-O-17.

FOR SALE—Practice of deceased physician. Complete E. E. N. & T. instruments and equipment. Mercury, quartz and radiant lamps, Victor vario frequency, Wappler wall plate, complete deep therapy x-ray installation, including 140 Kv. shock proof tube and stand, 200 Kv. tube and table. Radiological journals and medical books. Write the Journal C-O-19.

FOR SALE—Complete fixtures of fully equipped eye, ear, nose and throat office. Doctor retiring. Leaves an excellent, unopposed EENT practice in attractive college town, with business in excess of \$10,000 last year. Write the Journal C-O-22.

FOR SALE—Kelley-Koet x-ray transformer and control with Coolidge equipment, type J, serial 163, price \$150. Also one diathermy, price \$40. Address Journal C-O-21.

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We especially invite your counsel and cooperation when combination of surgical therapy is evident.

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Available in vials of 10 cc., 80 units in 1 cc.



AUXILIARY

PRESIDENT'S MESSAGE

According to reports, auxiliary meetings are in progress all over the state. Many interesting and educational programs are being held this year. All auxiliaries, small and large, can accomplish a splendid job of distributing authentic health information, if they will see that Hygeia magazine is made available to the public. By this method we cannot measure the good we have done. The Hygeia contest ends January 31—I do hope Kansas succeeds in winning one of the cash awards.

The time is at hand when membership dues must be collected. Dues are \$1.00 per capita and are to be sent by the county treasurer to the state secretary, Mrs. H. L. Regier, 2000 Washington Boulevard, Kansas City, Kansas, by January 1. With the dues send two copies of the names of members and their addresses, listing the names as they are listed in the telephone directory so that our year book may be correct. If every member will make an effort to secure a member-at-large in the sections of Kansas where there are no auxiliaries, we can increase our membership so as to compare favorably with other states in the North Central region in which we are classified. North Central region comprises the eleven states of Illinois, Indiana, Kansas, Michigan, Minnesota, Mississippi, Nebraska, Ohio, South Dakota, and Wisconsin. Last year we ranked eighth in membership. Let's try to move Kansas in a higher bracket.

I attended a dinner meeting of the Nemaha County Medical Society in Sabetha on October 17, with Dr. and Mrs. A. H. Haynes and Dr. and Mrs. F. E. Wrightman as hosts and hostesses. They were interested in organizing an auxiliary and decided to do so, completing their plans at the next meeting. Mrs. Conrad M. Barnes, Seneca, is the new president. Mrs. W. R. Dillingham, Salina, corresponding secretary, accompaned me. We were house guests of Dr. and Mrs. Barnes. Naturally I am interested in the auxiliary program, but after I saw Dr. Wrightman's and Dr. Barnes' homes I am a real antique enthusiast. Such beautiful antique furniture and glassware is difficult to imagine. If you are in that section of Kansas, don't fail to see their collections. I returned from my first official auxiliary visit with the memory of a delightful meeting with most interesting people. Enroute we visited with Mrs. M. A. Brawley, Frankfort, and Mrs. W. R. Breeding, Marysville, both Marshall county auxiliary officers. Also talked with Mrs. Gomel, Washington, about reorganizing their Washington county auxiliary.

Your president and your president-elect, Mrs. Hugh A. Hope, will attend the national board meeting of the Woman's Auxiliary on November 16 and 17, at the Palmer House in Chicago.

-Mrs. Leo. J. Schaefer.

ARCHIVES AND HISTORY

The archives of the State Auxiliary should contain:

- 1. Copies of the president's messages.
- 2. Copies of programs of the state officers and chairmen.
- 3. Copies of important communications.
- The annual report of the president, her officers and chairmen.
- 5. The history of the auxiliary for the year.
- Other material which is considered valuable for future reference.

The history of the State Auxiliary should consist of:

- A list of names and addresses of officers and chairmen of standing committees.
- A list of those holding national offices and honorary positions.
- 3. Objectives for the year.
- Outstanding contributions made by officers and chairmen during the year.
- 5. A brief summary of the annual meeting.

This has been compiled and with the archives is filed in the Kansas Historical Building under Kansas State Medical Auxiliary.

-MRS. C. D. BLAKE, State Chairman.

LABETTE COUNTY NOTES

The Labette County Medical Auxiliary met October 25 at the home of Mrs. T. D. Blasdel of Parsons. Eleven members were present. During the business session Mrs. Charles Miller, Mrs. Blasdel and Mrs. J. A. Ebert reported on the state board meeting held in Salina in September, and Mrs. O. E. Stevenson read a letter from R. A. Raymond, secretary of the Kansas Crippled Children Commission, expressing appreciation to the group for their assistance during the clinic held recently in Parsons, at which time 106 crippled children were examined.

Dr. and Mrs. C. N. Petty, Altamont, and Dr. and Mrs. C. C. Price, Oswego, attended the southwestern medical meeting in Kansas City recently.

Dr. and Mrs. J. T. Naramore have received word that their son James, serving in the Pacific war area, has been awarded a medal for good behavior.

Kenneth Ebert, Oswego, has notified his parents, Dr. and Mrs. J. A. Ebert, that he has arrived safe in England.

Mrs. C. E. Joss, Mrs. H. T. Morris, Mrs. H. A. Alexander, and Mrs. Leo V. Turgeon were hostesses at the meeting of the Shawnee county auxiliary held October 9 at the Joss home. Mr. Bert Mitchner addressed the group.

Lt. O'Dowd, commanding officer of the WAC at the Smoky Hill Army Air Field, entertained the members of the Saline county auxiliary at its meeting on October 12 with a summary of the history of the WAC and the training and duties of its members. Fifteen members and seven guests enjoyed the program, which followed an all-hostess dinner at the Casa Bonita in Salina.

The October meeting of the Wyandotte county auxiliary was held October 13 at the home of its president, Mrs. Karl C. Haas. After the luncheon Dr. C. Omer West, guest speaker, spoke on woman's part in public relations, stressing the importance of keeping informed on legislative matters and health topics as presented in Hygeia. Mrs. Herbert Hesser, war chairman, asked the cooperation of the group in packing boxes for Russian relief. Miss Barbara Lou Horseman entertained with a vocal solo.

The busy wife is an asset to the auxiliary, if she is an informed member, because she has many opportunities to support the aims and purposes of the medical profession. As a member, she may become informed. She should know when to consult advisers.

The time has come when the auxiliary has so proved its worth that the question is not "Are you an auxiliary member?" but "Why are you not a member?"—Pennsylvania Medical Journal.

THE JOURNAL of the

KANSAS MEDICAL SOCIETY

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DECEMBER, 1944

Number 12

THE KANSAS EVALUATION STUDIES OF THE PERFORM-ANCE OF SEROLOGIC TESTS FOR SYPHILIS

Charles A. Hunter, Ph.D., and Frank Victor, A.B.*

Topeka, Kansas

In the fall of 1939 the Kansas State Board of Health approved the intrastate evaluation study of the performance of serologic tests for syphilis and appointed a committee to assist the director of laboratories in the selection of donors, and in arranging other details regarding the study.

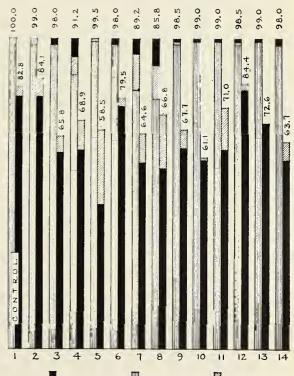
A form letter was sent to all hospitals, institutions and private laboratories explaining the purpose of the study, the recommendations of the committee on improvements of methods for determining the efficiency of serologic test performance and the brief outline of procedure. It was requested that all laboratories desiring to enter this study make application, and it was definitely stated that acceptance of the invitation was entirely voluntary on their part. Replies from 26 laboratories indicated that they wished to participate in the evaluation study.

The number of laboratories expressing a desire to enter the evaluation study was larger than anticipated and more than could be adequately handled, especially considering that this was our first study. A questionnaire was sent to the applicant laboratories to determine the number of tests performed in a week during a year. On the basis of replies to the questionnaire, it was decided to accept the thirteen laboratories doing the largest volume of work and run a second evaluation study on the remaining laboratories. Of the laboratories participating in the 1940 study, four were evaluated on complement fixation tests, six on complement fixation and Kahn tests, two on complement fixation and Kline tests, and one on Kahn and Kline tests. The complement fixation tests were on their own

modifications in most instances, although some were Kolmer's and one was Eagle's.

One of the recommendations of the committee was that we send out not less than 100 blood specimens from non-syphilitic donors and not less than 100 blood specimens from specially selected syphilitic donors. In order that we might meet these requirements, we desired to make arrangements for 225 donors, of which approximately 119 would be syphilitic donors and 106 non-syphilitic donors. It was thought that a few blood specimens probably would have to be discarded, due to the fact that laboratory results and clinical records did not agree, and that some of the specimens would be received in an unsatisfactory condition.

Arrangements were made to obtain one-half of the blood specimens from the Kansas City, Kansas, Health Department, and the other half from the



POSITIVE NEGATIVE DOUBTFUL

Graph No. I

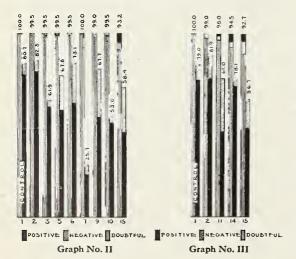
^{*}Division of Public Health Laboratories, Kansas State Board of Health.

Sedgwick County Health Department, Wichita. Two physicians were employed to help select the donors and obtain the clinical history, as well as to assist in the drawing of the blood; these physicians were employed by the Venereal Disease Divisions of the City or County Health Department, one in Kansas City and one in Wichita.

The syphilitic donors were arranged in three groups; approximately fifty per cent of the samples were obtained from donors with strongly positive reactions, thirty per cent from those with moderately positive reactions and twenty per cent from those with very slightly positive reactions. The Venereal Disease Research Laboratory of the U. S. Public Health Service agreed to run the Kolmer, Kahn Standard Precipitation and the Kline Diagnostic tests on these blood specimens, as a check on the laboratory which was to serve as the control.

Since thirteen laboratories were entered in the evaluation study, the inclusion of the Venereal Disease Research Laboratory and the control laboratory meant that we had to obtain approximately 75 cc. of blood from each donor. It was agreed that each donor, regardless of whether he was syphilitic or non-syphilitic, would receive two dollars for this quantity of blood. The blood was collected on Monday, Tuesday and Wednesday mornings. The number of specimens sent out varied from ten to fourteen per day.

Through the splendid co-operation of the health officers, Venereal Disease nurses, and the physicians employed to assist in this work, the patients had been previously interviewed and asked to report at the clinic at a certain hour. The patients' clinical records were kept, each was given a number, and, as a triple check, the patients were required to sign their names in another book, after their number, and to sign a voucher for payment.



The results of this study are presented in Graphs I, II and III.

In the fall of 1940 it was decided to run the second intrastate study in the spring of 1941, inviting all laboratories to participate on a voluntary basis. It was further decided by the Committee appointed by the Kansas State Board of Health, that all antigens be furnished free by the Division of Public Health Laboratories. It was also agreed that the number of specimens include at least 100 known syphilitic and 100 presumably normal bloods.

An invitation was extended to all laboratories to enter this study on a voluntary basis. The replies indicated that 31 desired to enter. Of this number, twelve wished to be evaluated on complement fixation and Kahn; ten on Kahn only; three on complement fixation and Kline; two on complement fixation, Kahn and Kline, and one on Kahn and Kline. Of the twenty laboratories desiring to be evaluated on the complement fixation tests, eighteen performed Kolmer's.

Arrangements were made with the U. S. Venereal Disease Research Laboratory to run all specimens of blood in order to check the results of the laboratory which was serving as the control. As in the case of the first evaulation study, the blood specimens were obtained by the Kansas City and the Sedgwick County Health Departments. The normal donors were medical students at the University of Kansas and students at University of Wichita.

All donors were paid four dollars each for approximately 150 cc. of blood. The physicians responsible for taking the clinical history and for assistance in bleeding were paid a fee of two dollars per donor.

The method of collecting and distribution of the blood was as follows:

APPARATUS

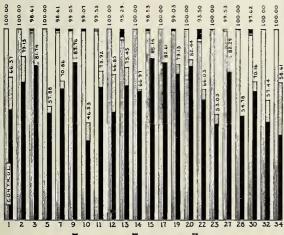
- 1. Test Tubes—The test tubes were four by one-half inch in size, thoroughly cleansed, dried and stop-pered with corks, after which they were sterilized in the hot air oven. The tubes were numbered, using adhesive tape which had been stamped with a numbering machine. Each series of tubes was tied into bundles, of which there were 225; each bundle contained about 37 tubes bearing the same serial number.
- 2. Syringes and Needles—Syringes were of the 20 cc. capacity, thoroughly cleansed, and wrapped in cloth towels, so that each packet contained six syringes. These were sterilized in the autoclave.
- 3. Needles—A sufficient supply of 16, 18, 19 and 20-gauge needles was always available. These needles were placed in small test tubes, plugged with vari-

ous colored cotton to help distinguish the size. They were sterilized in the autoclave.

- 4. Test Tube Racks—Special racks were made by boring holes in the edge of a two-inch by three-inch board. The holes were of such depth that the test tube held approximately 4 cc. when filled to the top of hole. Also, the sides of the rack were partly cut away, so that the tube was visible. Each rack held 40 tubes, all bearing the same number, and one rack was used for each donor. By this method it was impossible to get the blood specimens mixed.
- 5. Mailing—The blood specimens were permitted to stand at room temperature for approximately two hours, after which they were sorted, packed and mailed, so that all laboratories would receive them by the following morning.
- 6. Report Forms—The laboratories were required to submit their results within seventy-two hours after receiving the specimens. The report forms were furnished, together with self-addressed envelopes. This form was similar to the one used in the federal evaluation study, except an additional column was added for giving the tube readings. Also labels were furnished for sending back the mailing containers and tubes. Each laboratory was requested to keep track of its postage and at the conclusion of the study a check was sent covering all postage.

RESULTS OF STUDY

The sensitivity and specificity ratings of each laboratory were calculated on the following basis; for sensitivity in the syphilitic group, one per cent was allowed for each positive, one-half per cent for each doubtful and no per cent for each negative. In the non-syphilitic group, the specificity was one per cent for each negative, one-half per cent for each doubtful, and no per cent for a positive. The ratings were calculated on identical specimen basis as well as total specimen basis, in accordance with



POSITIVE NEGATIVE DOUBTFUL

Graph No. IV

recommendations of the U. S. Venereal Disease Research Laboratory.

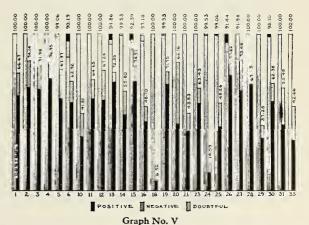
The findings for the 1941 study, as figured on the total specimen basis, are presented in Graphs IV, V and VI.

The results of the complement fixation tests in the 1940 study are given in Graph No. I. It can be seen that there were twelve laboratories participating, besides the U. S. Venereal Disease Research Laboratory and the control laboratory. Six of the entrant laboratories failed in both sensitivity and specificity, four laboratories failed in sensitivity and two laboratories in specificity.

The results on the Kahn test are given in Graph No. II; there were seven laboratories entered in this test. One laboratory failed in both sensitivity and specificity, five were low in sensitivity and none of these were below standard in specificity.

Graph No. III gives the results of the Kline diagnostic tests in the 1940 study. Three laboratories were entered for this test. All laboratories were low in specificity and two low in sensitivity.

The results of the complement fixation tests of the laboratories entered in the 1941 study are presented in Graph No. IV; twenty laboratories were entered for this test. Three laboratories were low in sensitivity and six low in specificity. The performance of eleven laboratories was satisfactory.



Graph No. V gives the results of Kahn tests done by twenty-five laboratories entered in the 1941 study. One of the laboratories was low in both sensitivity and specificity; six laboratories were low in specificity; nine were low in sensitivity, and nine met the standards established.

Graph No. VI shows results of the study on the Kline diagnosis tests of the laboratories entered in the 1941 study. It also shows that all six laboratories entered failed to meet specificity standards.

In order to compare the work of laboratories entered in the 1940 study with the quality of work per-

formed in the 1941 study, it was necessary to identify each laboratory, as identical numbers were not used in both years. Therefore, Table No. 1 shows the number of the laboratory for the 1940 study and number given to the same laboratory in 1941. Comparison reveals a general improvement in the quality of work performed in 1941, as compared to that done in 1940. The results of the 1940 study



demonstrated the need for improvement, and laboratories desirous of running satisfactory tests began studying their procedures to locate deficiencies. The Division of Public Health Laboratories, Kansas State Board of Health, offered its facilities as a training school, and a considerable number of serologists took advantage of this opportunity. It has been demonstrated that eval-

uation studies on the performance of serodiagnostic tests for syphilis not only tend to improve the quality of serologic diagnosis but also act as a stimulus in the improvement of all types of laboratory work

It is planned to continue these evaluation studies in Kansas working with the laboratories, offering them advice, consultation, training facilities and,

TABLE I IDENTIFICATION OF LABORATORIES IN 1940 AND 1941 STUDIES

By Number; for Comparison of Results

by Number, for Comparison of Results	
Number Given Laboratory on Graph 1940 Study	Number Given Laborator on Graph 1941 Study
1*	1
2**	2
3	3
4	7
5	12
6	20
7	19
8	16
9	11
10	15
11 -	9
12	Did Not Enter
13	5
14	17
15	14

**Control Laboratory
***U. S. Venereal Disease Research Laboratory

at a nominal cost, standardized antigens, with the hope that all laboratories desiring to continue to do serologic work will perform the tests in an acceptable manner, in accordance with the standards which have been adopted. The Kansas experience justifies a recommendation that all State Boards of Health provide training facilities, inspection and advisory service to all laboratories functioning in their respective states.

CONCLUSION

- 1. An evaluation study of this kind is important in determining the quality of work performed by laboratories.
- 2. As a rule, there was a general improvement in both sensitivity and specificity ratings of laboratories that participated in both studies. This clearly proves the value of such studies.
- 3. No participating laboratory in Kansas made a satisfactory rating in the Kline tests.
- 4. Standardized reagents and adequate equipment and supplies must be available in each laboratory. The procedure recommended by the author serologist must be followed, not only during the evaluation study, but also at all other times.
- 5. State Boards of Health should make training facilities available and maintain inspection and advisory service for all laboratories in their states.

PENICILLIN IN GAS GANGRENE

Report of the successful use of penicillin in a Cl. welchii infection.

Arthur A. McAuley, M.D. and Alonzo P. Gearhart, M.D.

Wichita, Kansas

Several cases of gas gangrene following war wounds have been reported as successfully treated with penicillin. Garrod¹ reporting seven cases from North Africa states that the infection was apparently checked in four, while in the remaining three the patients died from causes outside the control of penicillin. Lyons² reports two cases of anaerobic cellulitis due to Cl. welchii which were successfully treated with penicillin.

Due to the infrequency of gas gangrene in civilian practice, few cases have been reported to date. McKnight and his associates³ report one case in which penicillin was used with good results on a seven-year-old girl who developed a severe gas gangrene following a compound fracture.

A case of gas gangrene infection following a

simple comminuted fracture of the femur has come under our observation. The infective organism was identified by culture as Cl. welchii. We report this case as another occurring in civilian practice and treated in a civilian hospital. Penicillin was used as a treatment of last resort with excellent results.

CASE HISTORY

C. L., a 28-year-old white male previously in good health, was struck by a city bus while crossing the street. He was knocked to the pavement, a front wheel of the bus passing over his right leg, below the knee. He was brought immediately to the emergency room of St. Francis Hospital. Examination there showed a fractured right femur, not compounded, and several small lacerations on the left leg.



Fig. 1. X-ray of right femur taken on admission to emergency room,

There were no lacerations or cuts on the right leg. X-ray showed a badly comminuted fracture below the great trochanter with fragments in malposition. (Fig. 1) White blood cell count was 17,000 and hemoglobin was 14.3 Gms.

Four hours after admission a cast was applied covering the entire right leg and extending to the knee of the left leg. He was returned to his room in good condition. Circulation of the affected leg

seemed disturbed below the knee at this time and the cast was cut well above the knee and spread apart. On the following day it was noted that there was some discoloration of the toes and the entire leg below the knee. Orthopedic consultation was obtained at this time. It was the opinion of the consultants that the changes were due to circulatory interference as a result of crushing and not to gas gangrene. However, the condition progressed until the toes were definitely bluish-black. The cast was bivalved its entire length and a discolored area with blebs was noted on the anterior aspect of the right leg. A smear and culture were taken of the fluid in these blebs. The smear showed Gram positive spore forming bacilli and staphylococci. Culture identified the organisms as Cl. welchii. White blood count was 17,000 with a hemoglobin of eight grams.

One gram of sulfadiazine was started every four hours, but the condition of the patient steadily grew worse. It was decided to amputate on the fifth hospital day. The patient was taken to the operating room, but his condition was so grave it was felt that he could not stand the operation. He was returned to his room and his family was advised that little hope was held for his recovery.

At this time the patient appeared very toxic. The skin of his entire body assumed a tawny hue. The pulse rate went to 130. His face had become edematous and his eyes were swollen shut. His back showed pitting edema and there was a blue area in the mid-axillary region of the right side. The skin of the right thigh and lower abdomen was dusky in appearance.

Following his return from the operating room, transfusions of 500 cc. of whole blood and 500 cc. of plasma were given. 40,000 U. of pencillin in one liter of physiolgical saline with five per cent glucose was started by continuous intravenous drip in the morning and repeated in the afternoon. On the following day he received 200,000 U. and another blood transfusion.

On the fourth day after penicillin was started his condition showed marked improvement. His temperature had made a consistent drop but his pulse was still rapid. The gangrenous area had become localized. His back and left foot were still quite edematous but this was attributed to his low serum proteins, 5.1 Gms. per 100 cc., and to the fact that for several days prior he had maintained a positive water balance.

His condition had now become such that it was thought amputation of the affected leg would be advantageous. On his eighth hospital day, a guillotine amputation was done 5 cm. above the knee. During the operation bubbles of gas were seen exuding from the fascial layers. Part of the flesh had a cooked appearance. The patient stood the operation very well. A Thomas splint was placed on the stump and traction was made on the bone.

Microscopic examination of the tissue from the amputated leg showed many Gram positive rods

despite the fact that penicillin had been administered for four days previously. It was interesting to note, however, that the inflammatory reaction was much less than expected. Only an occasional segmented granulocyte was seen. The muscle tissue showed much



Fig. 2. X1500 (Photomicrograph by Dr. C. A. Hellwig), Gas bacilli in tissue from amputated leg. Note absence of inflammatory reaction.

swelling with loss of striations and nuclei.

Returning to his room he was given another blood

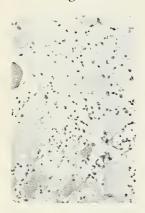


Fig. 3. X300 (Photomicrograph by Dr. C. A. Hellwig) One of a few areas taken from tissue of amputated leg showing considerable inflammatory reaction. Muscle tissue is necrotic.

transfusion from which he got a tremendous chill followed by fever of 106 axillary. Sponge baths, cool enemas, and aspirin brought his fever down. Following amputation his recovery was slow but definite. Tincture of digitalis was given daily with a resultant consistent drop in pulse rate.

One week after amputation a rise in temperature to 103 was noted. This was attributed to a cystitis and urethritis as a result of his having had an inlying catheter for ten

days. The catheter was removed and the bladder irrigated with Argyrol and boric acid. The tem-

perature promptly descended.



Fig. 4. X-ray of right femur taken ten days after amputation. Stump is in a Thomas splint.

Penicillin was discontinued on the sixteenth hospital day after having been administered continuously for twelve days. A total of 1,580,000 units was given.

On the twelfth postoperative day culture from the stump was negative for Cl. welchii. Healing took place without further incident. The patient was dismissed on his thirty-ninth hospital day, exactly one month after the leg was amputated.

COMMENT

Penicillin is of unquestioned value in experimentally produced Clostridia infections. It seems to be of equal value clinically. Radical surgical procedures will doubtless continue to be necessary in severe cases, but penicillin should allow the patient to go and return from the operating room in better condition than previously.

Features of the case presented worthy of comment are as follows: No site for the entrance of the infection was noted. There were no lacerations or abrasions visible anywhere along the leg or thigh. The possibility of microscopic abrasions must be considered. Gangrene did not begin at the

site of the fracture but midway between the knee and ankle. This area had been subject to a crushing injury when the front wheel of the bus passed over it.

Tissue from the amputated portion of the leg showed numerous gas bacilli despite the fact that penicillin had been administered for four days previously and that the patient was clinically much improved. The inflammatory reaction was much less than is ordinarily seen when gas gangrene is treated with other methods.

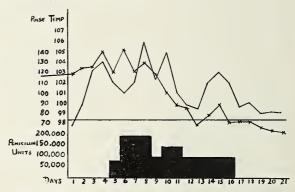


Fig. 5 Chart showing pulse, temperature, and dosage of penicillin. Fever peaks on eighth and tenth days are due to transfusion reactions; that on fifteenth day caused by a cystitis.

The temperature curve in this instance does not give a true picture of the patient's clinical response to penicillin. Since the chart shows maximum temperatures, each reaction to plasma or blood transfusion is recorded. The patient had some temperature increase with every transfusion. One week after the amputation a cystitis also caused a rise in temperature altho the patient was clinically much improved.

SUMMARY

A case of gas bacillus gangrene, identified by culture as Cl. welchii by culture, following a simple comminuted fracture of the right femur is presented. No portal of entry for the infection was discovered. After failure to halt the gangrenous process with sulfadiazine, penicillin was given by continuous drip intravenously for twelve consecutive days. A total of 1,580,000 units was given.

The drug appeared life saving in this instance.

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- Dr. Fleming, discoverer of penicillin, coined the word and pronounced it "penny-SIL-in" with the accent on

"SIL."-Nassau Medical News.

MEDICAL SCHOOL

DUPLICATED PELVES . . . VISCERO RENAL COMPLEXES*

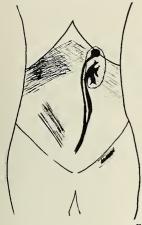
O. W. Davidson, M.D.

Kansas City, Kansas

In searching for the cause of visceral disturbances one should not overlook the possibility of an anomaly of the kidney as shown in Figures I and II below.

Congenital anomalies of this type frequently give bizarre abdominal symptoms that escape detection unless a rather careful study is made of the urinary tract.

In such conditions the upper pelvis is practically always the offending area. Infected urine may escape only intermittently. However, if this escape with release of back pressure is accompanied by relief of



F.39.ATTACKS OF CHILLS.
CHILLS ASSOCIATED WITH
BACKACHE AND HEADACHE.
VERY NERVOUS.
GALL BLADDER & APPENDIX
REMOVED.
NO BLADDER SYMPTOMS.
ATTACKS CONTINUED 11YRS.
UROLOGIC STUDY...
DUPLICATED RENAL PELVIS

INFECTION UPPER POLE.

Fig. I

referred symptoms, the kidney may not be questioned for some time.

As has been pointed out in previous articles, crossed reflexes can and do occur in connection with renal pathology whereby dominant symptoms are referred to the opposite kidney or into abdominal organs remote from the exciting area.

Such conditions are depicted in Figure I. In this case symptoms referred to the right abdominal quadrants continued after a cholecystectomy and an appendectomy. Persistence of abdominal complaints, headache, backache, and recurrent temperature elevations led to investigation of the urinary tract.

The findings in this instance represent one of the variations of such anomalies. The ureter was not completely duplicated and retrograde pyelograms failed to give the exact answer because the one

*Fifth of a series prepared for the Kansas State Medical Journal

ureteral catheter on the affected side passed to the lower pelvis. The deformity of the kidney pelvis and the size of the renal shadow on that side, however, aroused suspicion and it was neccessary to use intravenous urography to complete the answer.



Fig. II

Another variation appears in Figure II which should be easier to prove if one makes a cystoscopic examination of the bladder and notes duplicated ureteral orifices. Occasionally anomalous ureteral orifices may appear in the urethra.

Fortunately such anomalies are rather rare. In some instances satisfactory relief can be obtained if adequately free drainage is maintained from the upper pelvis to enchance control of the infection.

Instances of complete ureteral duplication make it easy to catheterize and lavage both upper and lower pelvis. Where the ureter bifurcates above the bladder, one catheter passed in advance of the other through ureteral orifices may effect entrance into each pelvis.

If such manipulative measures combined with chemotherapy fail, then surgical removal of the upper pelvis and its ureter must be considered.

The desire to take medicine is perhaps the greatest feature which distinguishes man from animals.—Sir William Osler.

President's Page

To the Members of the Kansas Medical Society:

The affairs of your society are now undergoing a lull which sometimes precedes the storm. There are a number of items concerning medicine which probably will come up in the next legislature. One is proposed by the Legislative Council and would require Wasserman tests before the issuance of a marriage license. Another is sponsored by the State Board of Health and seeks authorization for the establishment of a division for cancer control and asks for an appropriation of \$15,000 a year to set up this division.

Our Statute Research Committee has given considerable study to various items that have medical implication. Among them are problems pertaining to the use of narcotics and an enabling act which is designed to permit the Kansas Medical Society to offer the people of Kansas prepaid surgical insurance similar to the act under which the Blue Cross sells hospital benefits.

It is not unlikely that the osteopaths will be in Topeka asking to be made doctors of medicine by legislation, instead of in the usual way.

I think it would be well for our members to interview our state senators and representatives and discuss these various proposals with them, so they will have an idea how the medical profession feels about the proposed legislation that will affect them.

Yours very truly,

M. Trueheart. M. D.

M. Trueheart, M.D., President

EDITORIALS

HISTORY OF ANESTHESIA

Editor's Note—This, the centennial of the discovery of ether, has been a year for reviewing its history. Every medical journal has commented on this subject and below the Journal of the Kansas Medical Society re-publishes excerpts of an address by John C. Krantz, Jr., Ph.D., Sc.D., of Baltimore, entitled "Anesthesia—Man's Redemption from Pain." This was the Horace Wells Centenary Lecture originally delivered before the Michigan State Dental Society and is here borrowed from the Bulletin of the School of Medicine, University of Maryland, October, 1944.

Pain is the arch enemy of mankind. All through the annals of written history man has ransacked this entire earth in order to acquire a surcease of pain. His real struggle began in the year 1776. In medicine that was an important year. From the point of view of man's relief of pain it was the year in which Joseph Priestley, that Unitarian minister of England, the discoverer of oxygen, made laughing gas.

Prior to the time of Joseph Priestley mankind suffered tremendous pain in surgical operations. The French surgeon Paré, during the middle of the sixteenth century, when operating anesthetized his patients with the wines of France and frequently augmented the narcosis with a sharp blow on the head with a mallet, and frequently he conferred permanent anesthesia on many of his unsuspecting patients.

Joseph Priestley had no idea that nitrous oxide would be useful in the alleviation of human pain and suffering. In the year 1800, at the turn of the century, Sir Humphrey Davy remade Priestley's gas. He suggested to the medical profession that in all probability this substance might be useful in the alleviation of pain produced by surgery, but a skeptical profession frowned upon the suggestion while men continued to suffer.

Four decades have passed and the year is 1844. The exact date is December 10 and in Hartford, Connecticut, a ripple of enthusiasm stirs throughout the town. A miracle worker is coming to town. He is Gardner Q. Colton, lecturer on chemical phenomena. He has a new gas and this new gas can make people act beside themselves. It can make a very peaceable man pugnacious. It can throw him into fits of anger. And that afternoon a dentist of Hartford, Connecticut, had flash through his scintillating intellect the idea of the possibility of using this gas in dentistry. That evening he took Mrs. Wells to hear Dr. Colton.

Time went on and Wells did not succeed in getting the use of nitrous oxide well established in his native town of Hartford. Owing to ill health he gave up his dental practice. He was then associated with Dr. William T. G. Morton. Wells went into the business of giving entertainments on natural phenomena and taking shower baths in order to recuperate his health. However, he could not get from his mind this fundamental concept that when man is in anger, in passion, in rage, or in a period of exuberance or exultation, he does not feel pain. Further, if by chemical agents such as chloroform, ether, or nitrous oxide one can produce similar psychic states, one could relieve pain. And that was the fundamental idea underlying anesthesia. It was the centerpiece and everything else was embroidery around it.

Down in Georgia, Crawford W. Long, a physician, in 1841 heard of a liquid that was being used to cause people great exhilaration comparable to alcoholic inebriety and the young physician got interested. There in Jefferson County he invited many people into his home and he used ether for inhalation purposes. These people would become exhilarated—ether frolics were born and they became very popular. Time went on and Crawford W. Long was warned by the people in Georgia to stop using this substance. He was dissuaded from going on with his experiments even though he had used ether to remove a cyst from the neck of Mr. James Venable and Mr. Venable apparently felt no pain.

Out of the South the scene of general anesthesia pushed north and now it goes from the hands of a physician again into the hands of a dentist as we look in at the work of Dr. Morton, associate of Dr. Wells. In Boston he persuaded the surgeon, Dr. John C. Warren, to permit him to use ether on one of his patients. The year is 1846. The date is October 16, and the group in the operating room is skeptical. Then carefully with his new mask Morton began to drop diethyl ether slowly, slowly, and then came that statement — that memorable statement — that has echoed down through the decades, when Dr. Morton looked up and said to Dr. Warren, "Dr. Warren, your patient is now ready." Dr. Warren looked down at the table and turning to the skeptics in the audience said, "Gentlemen, this is no humbug. Mr. Abbott is fast asleep."

I must tell you of the letter that Oliver Wendell Holmes wrote to Morton about six months after ether day in Boston. He said: "Dr. Morton, I have given great consideration to this agent which you have used in Boston and have selected for it a generic term, for I believe it will be on the tongue of every person who is to live anywhere on this planet. I have called it 'anaisthesia—want of feeling'." "Without perception" the name anesthesia was born when Oliver Wendell Holmes assigned that name to the liquid which Morton used in the City of Boston.

It was, however, not until Victoria, who in Eng-

land was more than a queen—she was an English institution—permitted chloroform to be used on her at the birth of her seventh son, Prince Leopold, that the voice of prejudice disappeared and chloroform took its rightful place among the general anesthetics. It was Victoria who knighted James Simpson for this great discovery.

In 1922 ethylene was added to the list of general anesthetics. Ethylene has an outstanding disadvantage. It must be given in very high concentrations—ninety per cent along with ten per cent of oxygen—and the mixture is extraordinarily explosive. The explosions have a catastrophic nature of going down in the bronchial tree of the individual and generally eviscerating him.

Time went on and in 1927 there was introduced into this country the compound known as avertin—tribromethanol. We sometimes hold the view, erroneously so, that avertin owes its anesthetic action to the fact it has bromide in the molecule. As a matter of fact, it is simply an ethyl alcohol of heavy molecular weight that penetrates deep in the lipoids of the central nervous system and by this deep penetration brings about narcosis. Avertin is administered rectally as an anesthetic. Its anesthetic dose and its toxic dose are close to one another, therefore the careful anesthetist today, when he wishes to use avertin, as a rule, uses about two-thirds of the anesthetic dose and augments the anesthesia with nitrous exide or diethyl ether.

Statistics on deaths of those people who have died under avertin anesthesia show that one in 2500 die, which is equal to the number of deaths that occur under chloroform anesthesia. Against that we have one in 12,000 with ethyl ether, and one in 1,000,000 with Horace Wells nitrous oxide.

In the year 1930 it occurred to the fertile mind of Chauncey Leake, now of the University of Texas, that it might be a prudent idea to combine ethylene, which is characterized by such a smooth induction, with ethyl ether, which is characterized by good and long abdominal relaxation. The compound, the cross between the two, the hybrid molecule might have advantages, and so the compound was prepared divinyl oxide—vinethene as you know it today. Vinethene is useful in dental practice owing to the rapidity of induction. Its potency is about four times that of diethyl ether and it is recommended for operations of short duration.

In the year 1932, in that laboratory of the University of Toronto adjacent to the place where Banting and Best discovered insulin, Lucas and Henderson, in looking for a better ethylene, succeeded in making cyclopropane and using it as a general anesthetic. This anesthetic gas will give deep surgical

anesthesia in concentrations of fifteen per cent against ninety per cent with nitrous oxide or eighty or ninety per cent of ethylene. Under cyclopropane anesthesia the patient is better oxygenated and has less postoperative sequellae, and at the same time less liver damage.

In the year 1937 it occurred to us at the University of Maryland Medical School that it might be a matter of prudence to unite if possible the molecules of cyclopropane and diethyl ether. Cyclopropane has its advantages. The advantages of ether are well established. After a series of experiments lasting over a period of more than six years, we succeeded in producing separate and distinct anesthetic agents which in their general chemical structure may be considered to be a hybrid of molecules between ethyl ether and cyclopropane. We succeeded in making a compound which the chemist would call an isomer-i.e., it contains the same atoms, the same number of atoms but arranged differently in space. Propethylene has been used hundreds of times. Its potency is about four times greater than that of ethyl ether, its concentration in the blood twenty-five mg. per cent under deep surgical anesthesia in contrast to 150 mg. per cent with diethyl ether. In it we believe we have developed a new principle in general anesthesia. Other volatile anesthetic agents enter and leave the body unchanged. Properhylene is partially broken down in the human body into acetone and acetic aldehyde, each substance being less toxic than properhylene itself. It is interesting after a two-hour anesthesia, as the patient is being lifted to the surgical carriage, to see him open his eyes and regain complete consciousness. The boiling point of propethylene ether is 55 degrees C. compared to thirty-six degrees C. for ethyl ether, which makes it available in tropical countries where ether is difficult to administer.

We do not know—only time will tell—whether in this centenary year of anesthesia we have added another useful anesthetic agent to the armamentarium of the anesthetist.

ANNUAL MEETING

Upon invitation of the Sedgwick County Medical Society, the 86th annual meeting of the Kansas Medical Society will be held in Wichita on May 16 and 17.

Because of war time restrictions this will again be a two-day streamlined meeting but it will be complete with scientific and technical exhibits. There will be an annual banquet and a meeting of the Auxiliary at the same time.

Future issues will carry further announcements as the local committee completes its plans. We know they are preparing an outstanding program designed to place this in your memory as one of the finest annual sessions of all time.

MEDICAL CARE FOR EVERYONE

Everyone is voicing his opinion on the subject of medical care. Emotional appeals have arisen from all sides declaring that something must be done. Government, labor, industry, agriculture, medicine have each approached this problem from individual points of view. They have spread their propaganda, utilizing all resources at their command, calling on statistics to strengthen their story, begging the public to support them.

One group wants complete socialization of medicine, another prefers the extension of insurance programs. One group calls attention to selective service rejections, another wrangles over the high cost of medical care, and a third gets its headache over the physician shortage. Cultists have seized the flying coattails and are riding along hoping that some small benefit may ultimately fall their way.

The story from beginning to end has been garbled. The public is just as confused as government. And the medical profession certainly has not found a clearly defined position to adopt. Frenzied by pressures on all sides we have here and there compromised and invariably found new pressures added. We reluctantly accepted restrictions imposed under the E. M. I. C. program and then received more regulations as a result of the first. Ringing in our ears are cries of physician shortages which we know exist in places, but we recall the urgent need of three years ago for doctors to enter the service. We met this need and today stand helpless before loud and not always well informed groups who claim we should do more for civilians.

Labor, ignoring the profession, is using medical service as a pawn in its bitter struggle with industry. And industry withering under the heat of continual blasts has conceded occasionally to these demands. The medical profession is consulted after the pact has been made when all that remains for discussion is cost.

Nor is this all. The full story has been broken into innumerable segments in newspapers, magazines and over the air. It is time, we believe, that directional signs be erected. It is time that we mark basic principles and surely no group is so qualified for this task as the medical profession. It is time for the doctor to speak.

He should say that everyone is entitled to adequate medical care regardless of his financial condition. But it is not the responsibility of the doctor alone to bring this to pass. Surely, the doctor will help as he always has before. However, if society wants to adopt this as a basic provision for its well-being, then society must prepare to accomplish it. In other words those who are well and strong must assist those who are sick and weak. This means that the well-to-do cannot expect as large a return for their investment in this program as those who are poor.

We have purposely evaded the issue of how this should be accomplished because that resolves itself into innumerable local questions. It could span the entire list of medical care plans but we certainly believe the doctor should have a voice in this decision.

In the second place the doctor should answer the argument that our national selective service rejection rate is too high. It is not unfair to remind ourselves that this examination rejecting men for the rigors of war when for an entire generation we have planned only toward peace, does not necessarily mean we grew a generation that was not physically fit.

Social planners should know that you can no more confer good health upon sick people through legislation than you can use the same means to make a good doctor out of a poorly trained one. A person's health, whatever else it may also be, is first of all an individual problem. Education is slow and tedious but nothing else on earth will bring him to a doctor. He must first recognize his defect and then must have confidence in the medical profession's ability to help him.

Here, perhaps more than anywhere else in our efforts at public relations, have we neglected our responsibility. Had this factor been supplied adequately there would today be less misguided attention concentrated on the patient's ability to pay for medical care. We believe this also should be made a part of our educational program.

A person's health is an individual problem. If he can pay the cost of correction, why should he not expect to do so? If he prefers the budget system, then plans are available for him to follow. If he can pay nothing, then in the interests of national health it becomes the duty of society to provide this cost. But even this presumes his personal interest in better health and that must be taught him first of all.

The medical profession should also speak of hospital and physician shortages. The doctor, like everyone else, faces the necessity of earning a living. He, like everyone else, will migrate into areas that offer profitable opportunities. But even stronger than that is the doctor's desire to perform good service. For that he needs hospitals and laboratory facilities. So it is not by accident alone that certain areas lack medical care. The doctor often cannot build his own

hospital so if the community will not he has every reason to locate elsewhere.

All this is elementary, of course, but that is the very purpose of mentioning the subject again. These elementary factors have not been disposed of. They have been evaded in favor of ethereal planning on end results. So we should warn these dreamers, for who else can, that any program of medical care presumes that there will be doctors to administer the program and that somehow the public must be made to seek medical care.

These are only two possible means by which this end may be reached. The first is to invoke strict regulations governing the right to practice medicine and to establish attractive working conditions for doctors in all areas, thereby providing medical care of quality and in fair distribution to all localities. Then the public must be taught the value and the importance of these services so the individual will seek care when needed.

The second possibility is in forthright compulsion. All persons will be required to have medical care and the doctor will be appointed by the government to give his services. This implies his training by government order and certainly includes technicalities that even the most starry-eyed reformer has not yet imagined.

They may destroy what we rather fondly speak of as the physician-patient relationship, that implicit faith the patient has in his doctor, knowing that the doctor's personal interest in him will make him well. They may argue with Hitlerian assurance that the state will give equal care to all, but unless these reformers solve basic problems their cries will bring chaos.

If the layman, under socialized medicine, selects his own doctor, will he choose more wisely than he does today? Will the cultist and charlatan pass out of existence? Will government control eliminate fraud? If those things cannot be accomplished, then what do they hope to gain that we could not now offer under the present system of medicine a great deal better and for infinitely less cost.

EXAMINATIONS IN OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for candidates will be held in various cities of the United States and Canada and by special arrangements at Army and Navy Stations on Saturday, February 3, 1945. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year.

Arrangements will be so far as is possible for candidates in military service to take the Part I examination

(written paper and submission of case records) at their places of duty, the written examination to be proctored by the commanding officer (medical) or by a medical officer designated by him. Material for the written examination will be sent to the proctor several weeks in advance of the examination date. Candidates in military service who wish to do so may send their case records in advance of the examination date to the office of the secretary. All other candidates should present their case records to the examiner at the time and place of taking the written examination.

The office of the surgeon general (U. S. Army) has issued instructions that men in service, eligible for board examinations, be encouraged to apply and that they may be ordered to detached duty for the purpose of taking these examinations whenever possible. The office of the surgeon general of the U. S. Navy presumably takes a similar attitude on this matter.

The place of the Board's Part II examination in May or June 1945 has not yet been decided, but it is likely to be held in the city nearest to the largest group of candidates. The exact time and place will be announced later.

If a candidate in service finds it impossible to proceed with the examinations of the board, so that his plans are thus interrupted, deferment of parts of these without time penalty will be granted under a waiver of published regulations covering civilian candidates.

For further information and application blanks, address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

ANNUAL DUES PAYABLE

Notices have been mailed to the secretaries of county medical societies to advise that dues for 1945 are now payable, and, as in the past, provision is made for members serving in the armed forces. In accordance with plans adopted by the Council on February 9, 1941, those serving in a military capacity are exempt from payment of state society dues.

It is urged that all county secretaries send a complete report on physicians in their localities to the executive office so that records may be correctly maintained.

FIVE FELLOWS IN COLLEGE OF SURGEONS

Five Kansas surgeons have become fellows in the American College of Surgeons in 1944, according to an announcement received this week from Dr. Malcolm T. MacEachern, associate director. The five so recognized are Dr. John A. Grove, Newton; Dr. Louis R. Haas, Pittsburg; Dr. Lee Verne Hill, Kansas City; Dr. Arnold G. Isaac, Newton; and Dr. Donald C. Malcolm, Clifton.

A. M. A. MEETING IN JUNE

The ninety-fifth annual session of the American Medical Association will be held in Philadelphia June 18 to 22, 1945, instead of in New York City, as was announced previously. The change was made because of war conditions which make it impossible for the session to be held in New York. Physicians who plan to attend are urged to limit hotel reservations to the minimum amount of space necessary and to share accommodations when possible.



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• The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.

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EXECUTIVE OFFICE

In November Dr. F. R. Croson, Dr. E. H. Decker, Dr. J. F. Hassig and your secretary attended the annual meeting of state secretaries and editors at Chicago. Among the many papers presented the following, we believe, might be interesting to you.

Lt. Col. Harold C. Lueth, liaison officer of the Army Medical Corps, spoke of the returning medical officer. Replies from more than 11,000 men in the service indicate that 58 per cent hope to take extended post graduate education. An additional 24 per cent want short refresher courses, and 18 per cent prefer to go directly into private practice.

A questionnaire has been sent to each state society which asks for information regarding all areas of the state. For instance, they want to know the number of dwelling units located in each county, the per cent that are owned by their inhabitants, the number of telephones, hospital facilities, doctors, schools, as well as the story of the amount of sales and many other things.

Once completed, there will be available at the central office in Chicago a record of facilities all over the United States. Any officer is welcome to write for information on any prospective location. Then, as soon as he replies expressing an interest, this letter will be forwarded to the state medical society for further correspondence.

This is simply an attempt to assist the doctor and in no way will the office become an employment agency. The information will be available to the doctor but final arrangements will be made through the state office.

The plan looks good to us. We are now toying with an idea to carry this further as far as Kansas is concerned. At the risk of boring our members in service we intend to write each doctor a letter asking where he hopes to practice after the war, if he would be interested in an area we now believe will need a physician after the war, and what type of post graduate education he would like.

Of course, present opinions are subject to change, but this will at least give us an indication of which areas will need additional medical service. Or take a community which may support two doctors of which one is now in service. Should he state definitely that he will not return to this location, it would be to the community's benefit if we knew that now. On the other hand, we believe that we might assist the doctor if we know he plans to return to a definite location.

For the time being these are still plans, but some such procedure, we believe, will assist both the local community and the medical officer. We welcome any suggestions you care to give us.

But back to the convention. We heard a critical comparison of cash indemnity and medical service plans which will be discussed in a future issue. And of course the E. M. I. C. program was bandied about. One speaker advocated that dependency be declared from the time of conception and that the wife be given allotments as of that date. Then she could arrange for her own medical and hospital care. We seem to recall somewhere a statement from the United States Children's Bureau that soldiers' wives are not capable of handling this much money and that they cannot properly select medical care. It occurs to us that more than one boy whose father would not trust him with the family Ford is now piloting a bomber into enemy gunfire, so it could be that his wife also might be more resourceful than the Children's Bureau believes.

But before the discussion gets out of control, may we stop and wish you each a merry Christmas and a happy New Year. This comes from each of us at the executive office.

INTERNATIONAL STANDARD FOR PENICILLIN

Action to procure worldwide uniformity in notation and dosage of penicillin was taken recently at a conference for the standardization of the drug, held in London under the auspices of the health section of the League of Nations. The conference decided upon a pure crystalline preparation of a sodium salt of penicillin G as the international standard, and defined the international unit as the penicillin activity contained in 0.6 microgrammes of the international standard.

The conference, attended by Sir Alexander Fleming, father of penicillin, three delegates each from the United States and Great Britain, and one delegate each from Australia, Canada and France, also adopted a working standard. This working standard, for distribution to laboratory workers, consists of a calcium salt of penicillin, 2.7 microgrammes of which were accepted as containing one international unit of penicillin.

Agreements of this kind were first reached for antitoxins in 1921, when the health committee of the league took up the question of measuring the activity of a number of modern biological remedies in order to obtain international uniformity by agreements to use a common set of standards and units. Standards for vitamins, hormones, insulin, digitalis and arsphenamine were subsequently decided upon, with the result that today the activity of over thirty biological products is being assessed in terms of international standards.

Delegates to the conference from the United States were Dr. R. D. Coghill, Northern Regional Laboratory, Peoria, Illinois; Dr. R. P. Herwick, chief of the drug division of the Food and Drug Administration, Washington; and Dr. M. V. Veldee, chief of the Division of Biological Control, United States Public Health Service, Washington. Attending as observers were Dr. E. Fullerton Cook, chairman, Committee of Revision of the U. S. Pharmacopeia; Dr. C. N. Leach, International Health Division, Rockefeller Foundation; and Dr. Hamilton Soutwork, Office of Scientific Research and Development.

PENICILLIN BY AIR EXPRESS

On the basis of recommendations by medical officers recently repatriated from German prison camps and hospitals, the American Red Cross has sent 5,000 tubes of penicillin by air express to the International Red Cross Committee in Geneva to be used for American prisoners of war held by Germany, it was announced today. The Red Cross plans additional shipments of medicines and medical supplies for prisoners of war in the light of the repatriates' reports.

MEDICAL SUPPLIES TO BE SOLD

The edition of the Treasury Department's "Surplus Reporter" having to do with medical supplies is to be issued this month, and those interested in receiving information on the supplies available should write the Regional Office, Treasury Department, 2605 Walnut Street, Kansas City, Missouri.



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MEN IN SERVICE

A letter to the Society from Capt. L. F. Steffen, serving overseas in a general hospital, included the following: "We are somewhere in New Guinea. Have just completed cutting our area of the jungle. Don't know when we will be set up to receive patients. So far have seen no one that I know from Kansas, but no doubt will have time to look around and see who is here. Best regards to all my friends."

Major F. W. Matassarin, formerly of Wichita, wrote from England, under date of October 28, that he is stationed in a very nice hospital there.

A former Topeka X-ray specialist, Dr. Guy A. Finney, has been advanced to rank of Lieutenant Colonel in the Army, and is chief of staff of the X-ray section at Camp Swift, Texas. He is a veteran of World War I.

Lt. Comdr. James S. Hibbard, who has been serving with the Navy in the South Pacific for two years, has returned to this country for a new assignment. While enjoying a short period of liberty, he visited friends in Wichita, his former home.

Lt. Phillip L. Galloway, Medical Reserve, began internship at Queen of the Angels hospital, Los Angeles, on

The Neurological Hospital, 2625 The Paseo, Kansas City, Missouri. Operated by the Robinson Clinic, for the care and treatment of nervous and mental patients and associated conditions.

November 12, after being graduated from the Kansas University School of Medicine. Before reporting in California, he enjoyed a visit in Anthony where his father, Dr. Horace L. Galloway, practices and operates the Achenbach Memorial hospital.

Three interns who recently completed their work at St. Francis hospital, Wichita, have received orders to report for duty as first lieutenants in the Army medical corps. Lt. John G. Hoffer has been stationed at Winter General hospital, Topeka; Lt. Robert G. Powell has reported at Jefferson Barracks, Missouri, and Lt. Arthur A. McAuley has begun work at Fort Jackson, South Carolina. Lt. Hoffer and Lt. McAuley are from Wichita, and Lt. Powell is from Galena, Kansas.

A Nazi flag which the Germans flew at St. Malo has been sent to relatives in Topeka by Capt. David Gray, serving the Army in the European theatre of operations.

Comdr. H. F. O'Connell, Wichita, has been transferred back to the States and is now stationed at the U. S. Naval hospital, Astoria, Oregon.

Lt. George A. Westfall, Jr., who recently received his degree from the University of Kansas School of Medicine, has begun his internship in a New Orleans hospital and on its completion will be assigned to active duty with the Army. He is the son of Dr. George A. Westfall of Halstead.





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Capt. Franklin W. Foncannon, MC, has returned from twenty-two months service in the South Pacific with the Army Air Corps and is now stationed at Randolph Field, Texas, where he is taking flight surgeon training, according to information received from his father, Dr. Frank Foncannon of Emporia.

Major A. A. Sprong, Sterling, has been chosen to represent the Hawaiian and South Pacific theatre of operations in a conference of top flight air surgeons specially selected by the chief of the Professional Services Division. The surgeons recently met at the AAF Personnel Distribution Command, Atlantic City, and will confer with hospital authorities on aviation medical matters and visit air forces patients and discuss individual problems relative to transfer to AAF medical facilities or to duty on a flying status in the Air Forces through PDC.

The office of the Surgeon General, Washington, D. C., announces the promotion of Dr. Peter E. Hiebert, Kansas City, Kansas, from the rank of major to that of lieutenant colonel. Col. Hiebert has been serving at the Station Hospital, Camp Bowie, Brownwood, Texas.

CHANGE OF ADDRESS

Capt. John S. Betz from the Alliance, Nebraska, Air Base to the Army Air Field, Pocatello, Idaho.

Lt. Comdr. H. O. Closson from Treasure Island, Cali-

fornia, to Naval Advance Personnel Depot, San Bruno, California.

Major K. W. Haworth from Indiantown Gap, Pennsylvania, to an APO out of New York City.

Lt. W. F. Stone from Pensacola, Florida, to Naval Air Station, Norman, Oklahoma.

Lt. Samuel T. Thierstein from LaGarde General Hospital, New Orleans, to Headquarters, Sixth Service Command, Chicago.

Capt. Leon W. Zimmerman from Station Hospital, Carlsbad, New Mexico, to Station Hospital, Luke Field, Phoenix, Arizona.

MAJOR MUNNS HERE

Major Clarence G. Munns, former executive secretary of the Kansas Medical Society who is now serving in the procurement division of the Air Surgeon's office, Washington, D. C., visited briefly at the Society's office recently.

Capt. Richard A. Twyman, MC, has discovered that waxed paper from the wrappers of cigarette cartons can be used to facilitate removal of surgical dressings when the usual non-adherent substances are unavailable. Holes are punched at quarter-inch intervals to permit drainage and irrigation. The waxed papers are washed with soap and water, placed in a shallow pan, wrapped like other surgical dressings, and then sterilized in the usual manner.



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CLINICAL CONFERENCE IN CHICAGO

The second annual clinical conference sponsored by the Chicago Medical Society for physicians of the Middle West will be held at the Palmer House, Chicago, February 27-28 and March 1, 1945. Reservations should be made immediately.

Since Chicago is one of the great medical centers of the world, with abundant clinical material and clinicians of national reputation, the program will include speakers who are widely known and well recognized and will be of interest to all physicians, general practitioners and specialists alike. The daily presentations will begin at 8:00 a.m. and continue all day throughout the three days of the conference, with a special banquet program Wednesday evening. Extensive scientific exhibits will be provided.

VOLUNTARY HOSPITALS WILL BE EXTENDED

What is to be the course of action of America's voluntary non-profit hospitals during the coming year? Donald C. Smelzer, M.D., has envisioned it in his address accepting the presidency of the American Hospital Association, numbering 3500 such hospitals of the United States and Canada, as (a) preservation of the values of the voluntary hospital system; (b) government aid for the care of the indigent; (c) government aid for public and voluntary hospital construction; (d) the extension of voluntary budgeting for the cost of medical and hospital care, and (e) extension of rural-urban hospital co-ordination.

"This program can be translated into action that will preserve for the American people the American hospital system, to which there is nothing superior in the whole world," he stated.

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and a

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HUTCHINSON KANSAS SALINA

Dr. Smelzer, director of the Germantown Dispensary and Hospital in Philadelphia, assumes the responsibility of the presidency at a time when the Commission on Hospital Care is initiating its comprehensive study of the nation's hospital facilities, and when delegates to the Association's Third War Conference in Cleveland have declared the advisability of Federal assistance in construction and in care of the indigent.

WESTERN SURGICAL ASSOCIATION MEETS

The Western Surgical Association held its first meeting since 1941 on December 1 and 2 at the Drake Hotel in Chicago. Twenty-four papers on surgical subjects were presented, and there was a good attendance in spite of many members being in military service. New officers elected are: president, Dr. J. C. Masson, Rochester, Minnesota; secretary, Dr. Arthur R. Metz, Chicago; treasurer, Dr. W. M. Mills, Topeka.

REGIONAL MEETING IN OKLAHOMA CITY

The regional meeting of the College of Physicians will be held February 22 and 23 in conjunction with a meeting of Oklahoma City internists. The states included in the region are Missouri, Arkansas, Texas, Oklahoma, and Nebraska. Speakers from Kansas will be Dr. Don Carlos Peete, whose subject will be "Rheumatic Fever," and Dr. G. M. Tice, who will speak on "The Usual and the Unusual in Gastro-intestinal Radiology."

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Although, three years ago, penicillin pro-Scientific Research and Development. duction was a matter of culture plates, laboraduction was a matter of units, today Penicillin tory flasks and tens of units, holding thous Squibb is cultured in giant tanks holding thousands of gallons of penicillin at one billions of units of penicillin at one Thus E. R. Squibb & Sons are today one of billions of units of penicillin at one

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DEATH NOTICES

Dr. James Clyde Butler, 72, who had practiced in Hutchinson for the past twenty years, died at his home there on November 14, after having been in poor health for four years.

Born in Mountain City, Tennessee, he studied medicine at the University of Tennessee and was graduated from the Lincoln Memorial University Medical Department, Knoxville, later taking special work at Johns Hopkins university.

He practiced for several years in Mountain City, served as chief surgeon in the Veterans' hospital at Johnson City, and then joined his brother, Dr. W. L. Butler, in operating a hospital in Stafford. After serving in World War I, he practiced in Knoxville for several years before coming to Kansas. He specialized in proctology and was a fellow in the American Medical Association.

Dr. John Magruder Sutton, retired physician of Lincoln, Kansas, died November 22 at the Ellsworth hospital. He was graduated from the University Medical College of Kansas City, Missouri, in 1908 and interned in Kansas City and Halstead. He had practiced in Lincoln for twenty-six years, and was a fellow in the American Medical Association. He is survived by his wife and two brothers, Dr. Richard Sutton of Kansas City, Missouri, and Dr. Sutton of Eagle Pass, Texas.

Dr. Albert A. Huber, sixty-four, a practicing physician in Kansas City, Kansas, since 1904, died December 4 at Providence hospital there.

Dr. Huber was graduated from the University Medical College of Kansas City in 1904 and immediately began practicing there. Never desiring to specialize, he was a general practitioner and became one of the well known "family doctors" in the city. A month ago he suffered a heart attack, from which he apparently was recovering until December 2, when he suffered a relapse.

Dr. John Arthur Bundy, sixty-six, died at his home in Hill City on November 26. He had practiced in Hill City and the adjacent territory since 1907, shortly after his graduation from the University Medical College of Kansas City.



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NEW OFFICERS IN LYON COUNTY

New officers for the Lyon County Medical Society were chosen at a meeting held in Emporia December 5. Dr. F. A. Eckdall will serve as president during the coming year, Dr. C. L. Patton will be vice president, and Dr. C. H. Munger will continue in office as secretary-treasurer. Dr. Clyde Wilson presented a paper, "Transfusion of Whole Blood."

RILEY SOCIETY ENTERTAINS

Members of the Riley County Medical Society entertained physicians from Pottawatomie, Clay, Cloud and Geary counties and from the station hospital at Fort Riley at a scientific meeting in Manhattan on November 21. Dr. William G. Gordon, associate professor of urology, University of Kansas School of Medicine, Kansas City, Kansas, spoke on "Modern Treatment of Cancer of the Prostate." Dr. G. A. Walker, associate professor of pathology at the same school, answered questions during an informal discussion of pathological matters.

MEMBERS

Dr. A. N. Gray, Burlington, was elected coroner of Coffey county in last month's election although his name did not appear on the printed ballot. He had been coroner for the county, but did not file for reelection.

Dr. Karl Menninger, Topeka, was guest speaker at the Jackson county health forum held in Kansas City on November 15. His topic was "Psychiatry in the War and After the War."

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Dr. R. J. Metcalf, who has served in the Navy as a lieutenant commander for the past two and a half years, has been released from active duty and is resuming his practice in El Dorado. During his naval service Dr. Metcalf was stationed at the San Diego marine corps base hospital and at Santa Fe, New Mexico.

Dr. John M. Mott, Jr., who was recently graduated from the Kansas University School of Medicine, has begun his internship in Providence hospital, Kansas City, Kansas. His degree carries the medical profession to the third generation in his family as his father, Lieut. Col. John M. Mott, is serving in the Army Medical Corps and his grandfather, Dr. S. S. Glasscock, is practicing in Goodland.

An article on chemical preservatives in food, written by Evan Wright, director of the food and drug division, Kansas State Board of Health, appeared in the November issue of Hygeia.

Dr. C. D. Updegraff, Greensburg, was elected coroner of Kiowa county, according to unofficial tabulation of the vote. No candidates' names appeared on the ballots for that office.

Dr. M. F. Stock, an eye, ear, nose and throat specialist, has moved to Lawrence and is practicing there. A graduate of St. Louis university, he has been practicing in Los Angeles for several years. He is a brother of Dr. Karl W. Stock of Topeka.

Dr. P. F. Theis, who has been practicing in Hugoton, has returned to his former home in Arkansas City and is practicing there.

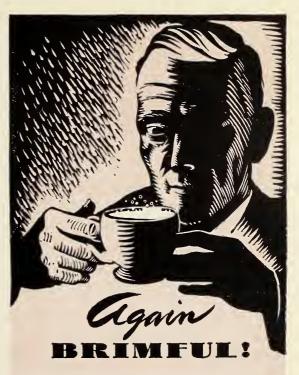
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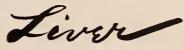
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AT VARIANCE ON STATE OF NATIONAL HEALTH

Stirred to wrath by reports from Washington in recent months that the nation's health is a cause for concern, that the United States is a "flabby, ailing nation," Malcolm W. Bingay, of the Detroit Free Press, unleashed an attack on politicians who are exciting the public over what he considers a normal condition. His editorial, headed "Trying to Scare Us," read as follows:

Well, I see the boys are at it again. American youth is soft and flabby and gone altogether decadent. There is no health in us and we're all headed for the demnition bow wows. Cassandra puts an onion in her handkerchief and her tears make the Mississippi River look like a creek.

Now it's that great medical authority Paul V. McNutt and Maj. Gen. Hershey, aided and abetted by Dr. Leonard Rowntree, the only one of them who should know anything about the subject. And with all due respect to Dr. Rowntree, he doesn't either. Nobody does. As I am in the same classification, I can speak freely. My answer to their contentions, is simple and scientific; just one word: Nuts.

The American people are the healthiest in all the world; the tallest, strongest, toughest, most durable collection of human beings ever to live on the face of the earth.

Before this war started we were told that American youth was utterly unfit to live. They were mad wastrels, sick in both head and body. There was no future for this country at all.

That's what the Nazis thought, too. But when Pearl Harbor was hit, what happened? Don't bother answering. We all know what happened. Eleven million of the most virile fighting men the world has ever known snapped into

uniform and have been thrilling the whole world ever since with their deeds of valor and their fighting stamina.

But we are still soft and flabby. One third of our people are physically and mentally unfit. All that sounds terrible until you begin to analyze what they are saving.

until you begin to analyze what they are saying.

Let's take a peek at that terribly sick "one third." They are all classed in F-4 as too feeble to fight. Well, we will start out at Briggs' Stadium with one. There's Rudy York, so big and strong that he makes a baseball bat look like a toothpick. With the possible exception of Babe Ruth he can hit a baseball farther than any other man ever in the game.

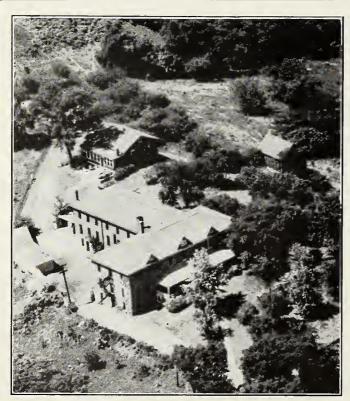
But Rudy is rejected for service because he has some kind of a kink in his knee. Take a gander at him and see if you can find anything decadent about him. Then there is Leo Durocher, "Lippy Lou," the toughest, fightingest baseball player in the National League. He was rejected because he could not hear as well in one ear as the other.

Then, also out at Briggs' Stadium, there is the mighty Dick Wakefield, just discharged from the Navy and not wanted by the Army. Probably has corns or is allergic to chocolate sundaes or something. I dunno. He could pose for a statue of Adonis.

Also, we have in our midst Frankie Sinkwich, All-American football star, rejected by the Marines and the Army because he has FLAT FEET! One of the fastest, toughest backfield players the game has ever seen. If you tell him he's a weakling and a sissy, Doc, you better do it by telephone—long distance at that.

I cite just a few instances to illustrate how much flapdoodle there is to this testimony about our youth being no good. You can multiply these cases by the thousands.

There is the historic case of the Kentucky mountaineer



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who walked seventy-five miles in three days to get to a recruiting station and was rejected because he had flat feet and therefore could not stand the strain of marching! So he walked back home-another seventy-five miles.

The medical standards set by the United States Army were so high that it is amazing they were able to gather in those 11 million. No such standards were ever demanded in any other nation. No such standards were ever set in any other American war.

And that "one-third" also takes in the wretched colored people of the South and the poor whites who for generations have been the victims of hookworm, malnutrition and every other disease that is associated with poverty. Also our own northern slum areas.

And last of all, these selective service "experts" have no standard to go by. Only in the first World War, when a universal draft was first put into effect, was there ever a survey made of American health. In all other wars nobody ever heard of x-rays, blood tests, and allergies. In the Civil and Spanish-American Wars physical examination was the last thing that was thought of. Nobody bothered examining anybody's teeth.

Dr. Rowntree says hernia, tuberculosis and venereal disease are the three chief causes for rejections. Our grandfathers took hernia as part of middle age. Today it is the simplest of medical operations. Tuberculosis, once the great white plague, is now classified as a controlled disease and is on its way out. As for venereal disease, there never was a war fought in our history with less evidence of it. And the medical profession knows that it can be eliminated within another ten years.

MEDICINE TO CHINA BY AIR

Air shipments of medicine into China set a new record in September, with forty-four tons flown over the Himalaya Mountains from India, Basil O'Connor, chairman of the American Red Cross, has announced.

The original Red Cross program of medicines for China called for shipment of ten tons per month, but increased need of drugs and medicines and added flying facilities have led to an increase that will provide forty to fifty tons a month

September shipments were of particular importance, since they were made up largely of sulfa drugs, some of which were flown immediately into an area where there had been outbreaks of plague.

Medical shipments are sent to Calcutta, shipped overland to the Assam air fields and flown from there into China.

EYE DROPS FOR "FLASH" BURNS

An outstanding source of eye injuries in shipyards and similar industries, according to K. A. Koerber writing in the American Journal of Surgery, is "flash" burns or actinic conjunctivitis, caused primarily by the ultra-violet rays produced when the welder strikes his arc. The eye condition gives rise to a series of unpleasant symptoms, and is suitably treated in the clinic. For home use, each welder with this ailment receives a quarter-ounce bottle of a specially prepared "Welder's Drops" made from pontocaine (0.25 per cent), ephedrine sulfate (0.25 per cent), menthol (0.10 per cent), glycerine (5.00 per cent) and boric acid solution (to make 100 per cent).

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KANSAS MEDICAL ASSISTANTS' SOCIETY

The Executive Council of the Kansas Medical Assistants' Society will meet at the Jayhawk Hotel in Topeka on Sunday, January 21, 1945.

The November meeting of the Shawnee County Medical Assistants' Society was held on the fourteenth at the offices of the Shawnee County Medical Society. The hostesses, Mae Evans, Leta Gahm, Madge Titus and Grace Brook, served dinner to forty-five members, after which Dr. J. L. Lattimore, Topeka, entertained with a talk on laboratory technique, using slides for illustrations.

A business session included discussion of a rummage sale planned for November 18, appointment of a committee to prepare entertainment for the Executive Council meeting in Topeka in January, and plans for assembling gifts for patients at Winter General Hospital at Christmas time.

Members of the Wyandotte County Medical Assistants' Society met November 28 at the Huron building in Kansas City. At the business session it was decided to grant membership to hospital secretaries, and the constitution was amended to raise dues to one dollar. Miss Vera Krepps reviewed "Trevelyan" by Angela duMaurier.

A Christmas party will be held December 14 at the home of Mrs. W. C. Miller, 944 Ann avenue, Kansas City.

WHOLE BLOOD TO PARIS

Blood from American civilians is now flowing through the veins of soldiers wounded in Europe within twenty-four hours after it is donated in this country, reports the office of the Surgeon General. Drawn from "O" type donors in Boston, New York and Washington, the blood is taken direct to Paris, flown by the Army Transport Command. A total of 750 pints is now being transported daily, and the need for both whole blood and plasma is becoming more and more urgent as the number of casualties increases.

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AUXILIARY

PRESIDENT'S MESSAGE

Your president and president-elect, Mrs. Hugh A. Hope, attended the national board meeting of the Auxiliary held November 16 and 17 at the Palmer House in Chicago. Thirteen national officers and directors, seven national chairmen of standing committees, twenty-two state presidents and fifteen state presidents-elect were in attendance.

This meeting operated under the new constitution and by-laws adopted at the June national meeting, which provides for a meeting of the Board of Directors and a separate conference of presidents, presidents-elect of state societies and national chairmen of standing committees. The conference elects its own chairman and secretary from among its membership. Mrs. R. E. Moseman, a national past president, was elected chairman, and your president was elected secretary. The national president, Mrs. David W. Thomas, presided at the conference until the chairman was elected and then presented her report. She stressed membership, bulletin, Hygeia, health education, juvenite delinquency, public relations, physical fitness, Red Cross assistance, and war participation, and asked all state auxiliaries to participate in the above program.

Dr. Adelaide Hoefel of Chicago discussed juvenile delinquency as one of the biggest problems of the present day.

Dr. Hammond, president of the Illinois Advisory Council, extended greetings. He stressed the importance of the Auxiliary in public relations, health education, and especially as a good will advocate in other women's organizations. He stated sixty per cent of the people believed in medicine, thirty per cent go here and there but finally return to medicine, and ten per cent go to quacks.

At the luncheon, Dr. Herman L. Kretschmer, president of the A.M.A., Dr. Roger I. Lee, president-elect of the A.M.A., Dr. Morris Fishbein, and Dr. W. W. Bauer, editors of the Journal of A.M.A. and Hygeia, gave short addresses. Dr. Kretschmer urged us to see that correct health information is given to the public and to assist with the juvenile delinquency problem in every way possible. Dr. W. W. Bauer discussed the various radio electric recordings on medical subjects available to radio stations free of charge and also a set of twelve records, "Health Heroes," for schools, selling for \$25.

The state presidents reported the progress of the Auxiliary in their states and outlined the program planned for the year. The most outstanding idea was the school of instruction for auxiliary officers and committee chairmen, as presented by the Illinois state president. I believe most of us feel the need of such instruction. If several schools of instruction could be held during the summer in various sections of the state with a state officer or state chairman presiding, each Auxiliary would accomplish more during the year. This idea will be discussed more fully at the state meeting.

The 1945 A.M.A. meeting will be held in Philadelphia instead of New York. We all left the convention hoping to meet again next June, each one of us inspired by contacts with other officers.

Best wishes for a Merry Christmas and Happy New Year.

Mrs. Leo J. Shaefer.

1945 STATE MEETING

The annual session of the Woman's Auxiliary to the Kansas Medical Society will be held in Wichita May 16 and 17. It is not too early to keep those dates in mind. The national president, Mrs. David W. Thomas, will be our guest, also Mrs. Eben J. Carey, national past-president.

While our program has not been planned as yet, I hope to have the luncheon May 16 in honor of the county presidents with all fifteen present bringing a report like this—all doctors' wives (1) a member (2) bulletin subscriber (3) two Hygeia subscriptions. I have an idea to submit to you for your approval, so all plan to be there, will you?

The luncheon May 17 will be in honor of the past state presidents with the national president as guest speaker. Keep those dates marked on your calendar.

WHERE SHOULD WE FIND HYGEIA?

- 1. In the home of every Auxiliary member.
- 2. In the homes of our friends as gifts from Auxiliary members.
 - 3. In the hands of every instructor of Home Nursing.
- 4. In every USO center and military camp recreation center.
 - 5. In every base hospital library.
- 6. In every community reading room, hospital, college, high school and institutional library and every doctor's and dentist's reception room.—Journal of the Iowa State Medical Society.

MEMBERS-AT-LARGE

Will each member of an organized Auxiliary secure one member-at-large and send the dues, one dollar, to Mrs. H. L. Regier, 2000 Washington Boulevard, Kansas City, Kansas, by January 1. The new member will receive a year book and membership card. Let us move Kansas into a higher membership bracket.

The Women's Auxiliary to the Wyandotte County Medical Society met November 10 at the home of Mrs. Harold V. Holter, Kansas City, for a one o'clock dessert meeting. Twenty-nine persons, including eight new members, were present. Mrs. Howard L. Porter entertained with a reading and Mrs. Paul W. Burres discussed "Leaves from a Chaplain's Diary." Mrs. Herbert Hesser, war chairman, gave out twelve cartons to be filled by members for Russian War Relief.

The home of Mrs. H. R. Hodson, Wichita, was the scene of a pre-Thanksgiving luncheon and meeting of the Sedgwick County Medical Auxiliary on November 13. Assisting the hostess were Mesdames G. E. Milbank, G. W. Kirby, G. A. Spray, John L. Vickers, V. L. Pauley, J. V. Van Cleve, E. D. Kilbourn, J. L. Beaver, W. T. Elnen and A. E. Hiebert. Mrs. D. W. Basham, who planned the program, presented Miss Elno Hartle, who spoke on "Precious Possessions."

A buffet supper was served to members of the Shawnee county auxiliary when it met November 13 at the home of Mrs. E. H. Decker. Mrs. J. G. Stewart, Mrs. M. B. Miller, Mrs. F. C. Taggart and Mrs. R. E. Pfuetze were assisting hostesses. Dr. Philip Riggs gave an interesting talk on stars and planets.

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